91-1749

No. _____

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1992

M. HISHAM TARABISHI, M.D.,

Petitioner,

v.

MCALESTER REGIONAL HOSPITAL, also known as McAlester Regional Health Center Authority Public Trust Status; THE MCALESTER CLINIC, INC.; LEROY M. MILTON, M.D.; GEORGE BROWN, M.D.; WILLIAM G. BLANCHARD, M.D.; SAMUEL E. DAKIL, M.D.; JOHN B. COTTON, M.D. STEVEN ATWOOD, M.D.; CHARLES K. HOLLAND, M.D.; KARL SAUER, M.D.; HERTZL V. SCHAFF, M.D.; JOE MCCAULEY, M.D.; and, DON SCHULLER, M.D.,

Respondents.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

PETITION FOR A WRIT OF CERTIORARI

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April, 1992

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QUESTION PRESENTED

DOES A HOSPITAL BOARD'S CONDUCT OF A SHAM PEER REVIEW PROCESS WHICH DAMAGES AND DEPRIVES A COMPETING MEDICAL DOCTOR OF PROPERTY, CONSTITUTE A *PER SE* VIOLATION OF THE ANTITRUST LAWS? IF SO, DID THE COURT OF APPEALS ERR BY CONSIDERING SUCH CONDUCT *ONLY* UNDER A MODIFIED RULE OF REASON STANDARD BY WHICH OTHERWISE ACTIONABLE JOINT CONDUCT AMONG COMPETITORS IN THE MEDICAL PROFESSION/HOSPITAL COMMUNITY (IN THE FORM OF "PEER REVIEW WITHOUT DUE PROCESS") IS NOT ACCORDED THE SAME ANTITRUST CONSEQUENCE AS JOINT ACTION BETWEEN COMPETITORS IN SIMILAR GOVERNMENT MANDATED, SELF-GOVERNING PROFESSIONS SUCH AS STOCKBROKERAGE, THE LEGAL PROFESSION, ETC.?

PARTIES TO THE PROCEEDINGS

The Petitioner, Plaintiff-appellant and cross-appellee below, is M. Hisham Tarabishi, M.D.

The Respondents, Defendants-appellees and cross-appellants below, are the McAlester Clinic, Inc., an Oklahoma professional corporation, McAlester Regional Hospital, an Oklahoma public trust hospital, and Leroy M. Milton, M.D., George Brown, M.D., William G. Blanchard, M.D., Samuel E. Dakil, M.D., John B. Cotton, M.D., Steven Atwood, M.D., Charles K. Holland, M.D., Karl Sauer, M.D., Hertzl V. Schaff, M.D., Joe McCauley, M.D., Don Schuller, M.D.

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OPINIONS BELOW

The January 24, 1992, Denial of Rehearing by the Court of Appeals for the Tenth Circuit is unreported and appears in the Appendix at A-1. The December 10, 1991 Judgment of the Court of Appeals is reported at 951 F.2d 1558 (10th Cir. 1991), and is reprinted in the Appendix at A-2. The May 4, 1989, Findings of Fact and Conclusions of Law of the District Court for the Eastern District of Oklahoma is unreported and reprinted in the Appendix at A-16.

JURISDICTION

The order of the Court of Appeals for the Tenth Circuit affirming the opinion of the District Court of the Eastern District of Oklahoma was entered on December 10, 1991. A timely petition for rehearing was denied on January 24, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. sec. 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Fourteenth Article of Amendment to the Constitution of the United States of America is set out in the Appendix at A-76. The Sherman Act, 15 U.S.C. sec. 1 and 2 are reprinted in the Appendix at A-77. The Health Care Quality Improvement Act of 1986, 42 U.S.C. sec. 11101 *et seq.* are set out in the Appendix at A-78.

STATEMENT OF THE CASE

In December of 1987, Dr. Tarabishi, an ear, nose and throat physician, and his professional corporation, M. Hisham Tarabishi, Inc., initiated this case in the United States District Court for the Eastern District of Oklahoma. Tarabishi alleged that the respondents, McAlester Regional Hospital ("MRH"), McAlester Clinic ("the Clinic") and the individual respondents (doctors who were members of the Clinic *and* members of the staff at the Hospital in various specialties) had violated sections 1 and 2 of the Sherman Act, 15 U.S.C. Sec. 1 and 2, and the antitrust and trade regulation laws of Oklahoma.

In 1979, Tarabishi began to work at defendant Clinic and was granted full staff privileges by MRH. In 1980, he left the Clinic and started his own medical practice, and became President of the Medical Society of Pittsburgh County, Oklahoma.

In 1978, MRH was the only existing hospital in McAlester, Oklahoma, formed by the merger of two pre-existing hospitals. Its position as sole hospital and provider of surgical services remained unchallenged until 1982, when Tarabishi attempted to establish an outpatient ambulatory surgical center (called TMD) to lower the cost of health care. Tarabishi hired two accountants and a health care industry consultant to conduct feasibility studies for such a center, who concluded that an outpatient ambulatory surgical center was needed in McAlester and that Tarabishi possessed the capability of operating such a facility.

In March of 1983, when he filed a Certificate of Need Application as required by Oklahoma law, Tarabishi requested that MRH maintain a "position of neutrality" relative to his application. Instead of neutrality, however, the MRH Board discussed the creation of its own outpatient ambulatory surgery service, and in May of 1983 announced that MRH would respond to the Oklahoma Health Planning Commission that the TMD Center "will duplicate the hospital's surgical services."

On May 12, 19, and 25, 1983, the Oklahoma Health Planning Commission held hearings on the Tarabishi application. MRH, which appeared through its Administrator, Comptroller and other officers, objected to the financial impact on MRH if the Clinic were established. Representatives testified that the TMD Center "would take away the paying, 'cream of the crop,' patients and

leave MRH with the 'low pay, no pay patients'." Oklahoma health care planners granted Tarabishi a license to operate such an independent surgery center, despite the vigorous objections of MRH.

After the announcement of his intention to open the surgical center, and after Tarabishi spoke out about the need to reduce high medical costs, MRH and its doctors subjected Tarabishi to a series of "peer review" proceedings, which ultimately cost him a loss of all privileges at MRH. Tarabishi's loss of privileges commenced *the very week* he officially opened his competing outpatient surgical center. Before Tarabishi expressed his opinion of high medical costs and announced his intentions to open TMD, no complaints had ever been brought against him by MRH. In fact, Tarabishi was, until that time, the most active surgeon on the MRH staff.

The complaints by MRH began in April, 1983, *immediately* after the filing of Tarabishi's Certificate of Need Application for his competing outpatient surgical facility. The "complaints" were premised on charges such as Tarabishi's "illegible" handwriting and his failure to attend certain Library Committee meetings. After the Certificate of Need for the TMD facility was granted, MRH notified Dr. Tarabishi that it intended to commence "corrective action" proceedings against him for a "therapeutic error" which had occurred four months earlier. In June and July of 1983, various hearing review and appellate committees or boards at MRH investigated Tarabishi. On July 17, 1984, eight days after Tarabishi's surgical center opened for business MRH revoked all of Tarabishi's staff privileges.

The loss of MRH privileges caused the Center to collapse. To continue his practice in McAlester, Tarabishi

needed access to MRH's operating room, emergency room, and other facilities and TMD was required to have access to MRH emergency care facilities by the Oklahoma Health Planning Commission. The collapse of the Center eliminated the first independent outpatient surgery facility in that region of Oklahoma. The facility would have been a force in lowering surgical prices and reducing unnecessary health services.

From October 17, 1988 through December 16, 1988, Tarabishi's case was tried to the Court. The Court entered Findings of Fact and Conclusions of Law, and held against Plaintiff on the following theories: individual monopolization of surgical health care services by the Hospital in violation of 15 U.S.C. sec. 2; individual monopolization by the Clinic; monopolization and attempt to monopolize non-surgical and office health care services by the Clinic; conspiracy to monopolize by all defendants; conspiracy in restraint of trade by all defendants.

Although the District Court dismissed all the antitrust charges against respondents, and refused to apply the *per se* standard to the peer review conduct of this case, it found that procedural due process had not been accorded Tarabishi, commenting that it:

> was shocked to discover that a physician's career can be – and in this instance has been – destroyed through patently improper proceedings. Peer review, as it is presently practiced, is fundamentally flawed. Appendix, at A-56.

The district court specifically found:

> The detailed examination in this case of the peer review proceedings involving Dr. Tarabishi leads the court to the conclusion that the proceedings would *not* pass muster even under the

> deferential standard described above [i.e., in the Health Care Quality Improvement Act]. In many instances, their was *not* "a reasonable effort to obtain the facts of the matter" or to provide adequate notice. The record is repleat with examples. * * * The deficiencies in these peer review proceedings go far beyond a failure to observe "procedural niceties," as defendants seek to characterize them. Tainting the entire process was the personal animus of many of the defendants towards Dr. Tarabishi. In one breath, a defendant doctor in this trial would testify that he virtually despised Dr. Tarabishi; in the next, he would testify that he could be and was "fair and impartial" while sitting in judgment. These assertions of objectivity are, quite simply, not credible. * * * The court cannot by any rational definition of the term "approve" the peer review proceedings under review.

Appendix, at A, 71-72.

The Court of Appeals for the Tenth Circuit affirmed the judgment of the District Court on antitrust grounds, holding that there was insufficient evidence to prove the asserted markets, and no evidence regarding the Hospital's or Clinic's power to control prices. Specifically the Court of Appeals rejected "plaintiffs' argument that defendants' legitimate and protected conduct in opposing Dr. Tarabishi in the Certificate of Need application proceedings furnishes the requisite specific intent to monopolize," citing the *Noerr/Pennington* doctrine. App. at A-28.

The Tenth Circuit agreed with the District Court that Plaintiffs' conspiracy claim was invalid, under Rule of Reason approach. The conspiracy claim was based on the peer review process, and the Court refused to apply the

per se analysis because peer review was involved, commenting that "defendants in this case terminated Dr. Tarabishi's staff privileges at least ostensibly because of a lack of professional competence or unprofessional conduct . . . " App. at A-29, n. 18. Given that they had to meet the standards of the Rule of Reason approach, said the Court, plaintiffs "once again simply failed to establish the required impact upon *competition.*" App. at A-31, emphasis in original.

The Court also denied Plaintiffs' Petition for a Rehearing, which argued that a *per se* standard should have been used because of the flagrant lack of due process involved in the peer review proceedings. The Court had all but ignored the specific findings of the District Court on this subject – appearing to conclude (in a footnote) that "public policy" precluded such a review of the peer review process. App. at A-23 - A-24. By inference, the Court found that appropriately conducted professional or industry self-regulatory proceedings had been accorded Tarabishi. App. at A-71 - A-72.

REASONS FOR GRANTING THE WRIT

I. PETITIONERS HAVE BEEN DEPRIVED OF A VALUABLE PROPERTY RIGHT IN VIOLATION OF THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT.

A. THE DUE PROCESS CLAUSE INSURES A FAIR HEARING.

This Court has held that " 'the fundamental requisite of due process is the opportunity to be heard.' " *Mullane v. Central Hanover Trust Co.*, 339 U.S. 306, 314 (1950), quoting *Grannis v. Ordean*, 234 U.S. 385, 394 (1914). The

hearing opportunity mandated by the Clause is one that "must be granted at a meaningful time and in a meaningful manner." *Armstrong v. Manzo,* 380 U.S. 545, 552 (1965). This hearing insures that citizens are protected from arbitrary action by government. *Fuentes v. Shevin,* 407 U.S 67, 80-81 (1972); *Daniels v. Williams,* 474 U.S. 327, 331 (1985) (and cases cited therein).

This Court has enunciated a two-part test for the application of the Due Process Clause: whether there is a protected interest, and what process is due, before there may be a deprivation of that protected interest. *Logan v. Zimmerman Brush Co.,* 455 U.S. 422, 428 (1982).

First, the Due Process Clause applies to Petitioners' action. Physicians have a constitutionally protected property interest in medical staff privileges. "[M]edical staff privileges embody such a valuable property interest that notice and hearing should be held prior to its termination or withdrawal, absent some extraordinary situation where a valid government or medical interest is at stake." *Northeast Georgia Radiological Assoc. v. Tidwell,* 670 F.2d 507, 511 (5th Cir. 1982). This Court has repeatedly held that such causes of action as Petitioners' are species of property within the meaning of the Due Process Clause. E.g., *Logan,* 455 U.S. at 428. "[S]ome form of hearing is required before an individual is finally deprived of a property interest," *Mathews v. Eldridge,* 424 U.S. 319, 333 (1976). Thus, "[t]he Court traditionally has held that the Due Process Clause protects civil litigants who seek recourse in the courts, either as defendants . . . or as plaintiffs attempting to redress grievances." *Logan, supra,* at 429. Petitioners are attempting to have their claims heard, and are entitled to the protections of the Due Process Clause.

Second, because the Due Process Clause applies to the Petitioners' claims, they must be afforded a meaningful hearing. Although private versus governmental interests may be weighed in determining the timing and nature of the hearing, the opportunity for a hearing does not depend on a balance and must be granted. *Board of Regents of State Colleges v. Roth*, 408 U.S. 564, 570-71 n. 8 (1972).

The peer review proceedings must be judged under the rule announced in *Boddie v. Connecticut*, 401 U.S. 371 (1971). Although the standard of scrutiny (strict or intermediate) was not precisely prescribed, Justice Harlan, writing for the Court, said, "that absent a countervailing state interest of overriding significance, persons forced to settle their claims through the judicial process must be given a meaningful opportunity to be heard." *Boddie*, 401 U.S. at 377. Justice Harlan then equated the meaningful opportunity to be heard with other fundamental rights such as "religious freedom, free speech or assembly." *Boddie*, 401 U.S. at 379. Finally, the Court held that although Connecticut's reasons for its law (that indigents must pay a divorce filing fee) were rational, they were insufficient to override the interest of persons who needed access to the courts to have their rights settled. *Boddie*, 401 U.S. at 381-82. Clearly, some form of heightened scrutiny is appropriate when examining laws that bar access to earning a livelihood in one's chosen profession.

B. PROCEDURAL DUE PROCESS MUST BE AFFORDED IN A PEER REVIEW ACTION.

1. The concept of Peer Review

Peer review is the right and duty of physicians to review the work of other physicians, and in doing so, to weed out those whose actions are inimical to patient welfare. Peer review is based on the ethical duties of physicians as professionals. The knowledge of the standard of care afforded a patient must be used to serve the interests of the patient affected and those of the larger community as well. *Medicare: A Strategy for Quality Assurance,* 119 (Lohr, ed. 1990).

Peer review is also required by the States; state hospital licensure statutes require a medical staff to engage in peer review.[1] Also, most states have statutes granting immunity from suit to peer review participants, generally qualified by a requirement that good faith or reasonableness govern in reviewing colleagues' work. *See,* e.g., Okla. Stat. Ann. Tit. 63, sec. 1-1709 (West Supp. 1984), Tit. 76, sec. 16 (West Supp. 1987); Ill. Rev. Stat. (1991) ch. 91, sec. 26; Jorstad, Note, *The Legal Liability of Medical Peer*

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[1] The duty to engage in peer review is underscored by common law, since a hospital can be held liable for patient injuries resulting from physician malpractice where the hospital was negligent in allowing the questionable physician to remain on the staff. *See, Darling v. Charlestown Com. Mem. Hosp.,* 33 Ill. 2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966); Hanson & Stromberg, *Hospital Liability for Negligence,* 21 Hastings L.J. 1 (1969); Peer Review Immunity Task Group of the American Academy of Hospital Attorneys, *Immunity for Peer Review Participants in Hospitals,* (Am. Hosp. Ass'n 1989); Nodzenski, *Where is the Quality in the Health Care Quality Improvement Act of 1986?* 22 Loy. U. Chi. L. J. 361 (1991).

Review Participants for Revocation of Hospital Staff Privileges, 28 Drake L. Rev. 692 (1978-9).

Peer review is also mandated federally and privately. Payment for Medicare is possible only in hospitals whose medical staffs have an effective review process, under Medicare "Conditions of Participation." 42 C.F.R. Part 482 (1986). The Joint Commission on Accreditation of Healthcare Organizations also requires "monitoring and evaluation" of patient care, for accreditation whether the hospital is public or private.[2] Thus, hospital bylaws invariably provide for peer review, specify options for corrective action and delineate the physician's right to appeal such actions.

Despite the critical nature of the procedures employed in evaluating the care rendered, the standards are broadly drawn, usually phrased as "physician failure to follow professional standards." Lang, *Medical Staff Peer Review: A Strategy for Motivation and Performance*, 80 (Am. Hosp. Assoc. 1990). These vague standards are applied to deny or withdraw privileges from a staff physician, with enormous impact. Exclusion of a physician from one

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[2] Joint Commission on Accreditation of Healthcare Organizations, *Accreditation Manual for Hospitals*, (1990). The JCAHO is a private accreditation organization, governed by a board composed of commissioners from the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Medical Association and the American Hospital Association. *See*, Roberts, Coale & Redman, *A History of the Joint Commission on Accreditation of Hospitals*, 258 J.A.M.A. 936, 939 (1987); Note, *Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act*, 29 Wm. & Mary L. Rev. 609 (1988).

hospital frequently leads to exclusion from others.[3] Exclusion by one hospital can lead to disciplinary investigation by local medical boards and difficulties in obtaining malpractice insurance anywhere the physician may attempt to relocate. Thus, frequently the excluded physician is confronted with a virtual prohibition against practicing medicine in the entire United States. In the instant case, Dr. Tarabishi has been unable to engage in surgical practice anywhere in the United States – even as a volunteer for the U.S. Army – as a result of the peer review decision in question herein.

2. Limitations on Peer Review: HCQIA

Heeding this Court's warning that "peer review" could be abused for improper ends, to further "anticompetitive activity" of private parties,[4] Congress became concerned about potential anti-competitive motives underlying peer review actions, and about the difficulty of obtaining a fair hearing. Congress enacted the Health Care Quality Improvement Act (HCQIA) in response to

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[3] *See* Grad, *The Antitrust Laws and Professional Discipline in Medicine,* 1978 Duke L.J. 443, 469-70; Drexel, *The Antitrust Implications of the Denial of Hospital Staff Privileges,* 36 U. Miami L. Rev. 207 (1982); Chafee, *The Internal Affairs of Associations Not for Profit,* 43 Harv. L. Rev. 993, 1021 (1930).

[4] In *Patrick v. Burget,* 800 F.2d 1498, 1506 (9th Cir. 1986), the Ninth Circuit specifically found that "the evidence, viewed in the light most favorable to Patrick, reveals shabby, unprincipled and unprofessional conduct on the part of the defendants," but held that "bad faith" on the part of the reviewers was irrelevant, given its reasoning that peer review activities of physicians in Oregon fall within the "state action" exemption.

what Congress described as the "need to provide incentive and protection for physicians engaging in effective professional peer review" against antitrust lawsuits brought by physicians facing disciplinary action.[5]

Congress specifically recognized the importance of providing an atmosphere for a fair hearing in peer review activities by providing *immunity from damages under federal and state law* for qualifying review bodies and individuals associated with, or assisting, the professional review action. 42 U.S.C. sec. 11111(a)(1).[6] That immunity, however, is expressly conditioned[7] on ensuring that the professional review actions comply with due process standards, as set forth in 42 U.S.C. sec. 11112:

For purposes of the protection set forth in section 11111(a) of this Title, a professional review action must be taken:

> (1) In the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) After a reasonable effort to obtain the facts of the matter,
>
> (3) After adequate notice and hearing procedures are afforded to the physician involved

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[5] 42 U.S.C. sec. 11101 *et seq.* (1986); *See,* Morter, Comment, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?* 74 Va. L. Rev. 1115 (1988).

[6] There is no immunity for damages that may be awarded under federal or state civil rights laws. See 42 U.S.C. sec. 2000e *et seq.*, 42 U.S.C. sec. 1981 *et seq.* There is no immunity from damages claimed by the United States or the Attorney General of a State. 42 U.S.C. sec. 11111.

[7] *See,* Peer Review Immunity Task Group of American Academy of Hospital Attorneys *Immunity for Peer Review Participants in Hospitals,* (Am. Hosp. Assoc. 1989).

or after such other procedures as are fair to the physician under the circumstances, and

(4) In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

The Act specifies what constitutes adequate notice and hearing in section 11112(b):

(1) The physician has been given notice of the proposed action and the reasons therefor, with the right to request a hearing within not less than thirty days of receipt of the notice and a summary of hearing rights;

(2) If a hearing is requested, the notice of the hearing must include the hearing date, which must be not less than thirty days after the date of the notice, the place, the time and a list of the witnesses expected to testify;

(3) If a hearing is conducted, the hearing must be held before a person or persons not in direct economic competition with the physician. It can be before either a mutually agreeable arbitrator, a hearing officer appointed by the entity, or before a panel of individuals. At the hearing the physician has the right to representation by an attorney or any other person, to have a record made, to call, examine and cross examine witnesses, to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and to submit a written statement at the close of the hearing.

The Act further specifies that failure of the professional review body to meet the conditions described in 11112(b) "shall not, of itself, constitute failure to meet the standards of subsection (a)(3)," which sets forth the requirement of "adequate notice and hearing procedures."

3. The Due Process Standards of HCQIA Should Be Applied To This Case.

The District Court below noted that while the HCQIA was only applicable to peer review actions commenced on or after November 14, 1986, and hence did not directly apply to the Tarabishi peer review proceedings, the criteria in the Act should be considered as those "which, logically, a reviewing court might ultimately consider." App. at A-70.

Legislative history indicates that the HCQIA's standards for due process were not intended to diminish the due process right of physicians. 132 Cong. Rec. H 11590, 11591 (daily ed. Oct. 17, 1986) (statement of Rep. Waxman).[8] Moreover, the HCQIA's criteria for a fair procedure mirror those set forth in the Joint Commission on Accreditation of Hospitals (JCAH) guidelines. Joint

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[8] Nor do the standards of the HCQIA preempt or override "any State law providing incentives, immunities or protection for those engaged in a professional review action that is in addition to or greater than that provided by this part." 42 U.S.C. sec. 11115. The Oklahoma statute dealing with peer review, sec. 1-1709 of the Public Health Code, provides:

> Physicians and others appointed to hospital utilization review committees for the purpose of determining the optimum use of hospital services shall be immune from liability with respect to decisions made as to such utilization and actions thereunder so long as such physicians or others act in good faith; provided, however, that nothing in this section shall be construed to relieve any patient's personal physician of any liability which he may have in connection with the treatment of such patient. Okla. Stat. Ann. Tit. 63, sec. 1-1709 (West, 1984).

Commission on Accreditation of Healthcare Organizations, *Accreditation Manual for Hospitals,* (1987).

C. PROCEDURAL DUE PROCESS WAS DENIED DR. TARABISHI

Dr. Tarabishi was not afforded procedural due process protections in the peer review proceedings. The District Court specifically found, after a "detailed examination . . . of the peer review proceedings," that they "would not pass muster, even under the deferential standard described above" [referring to the HCQIA standards]. App. at A-71. The District Court added: "In many instances, there was *not* 'a reasonable effort to obtain the facts of the matter' or to provide adequate notice. The record is replete with examples." App. at A-71. The District Court specifically found that the peer review actions were not taken "[i]n the reasonable belief that the action was in the furtherance of quality health care," and thus failed to meet the first requirement of HCQIA. Nor did they meet the second criterion of sec. 11112(a), namely that action must be taken only "*after* a reasonable effort to obtain the facts of the matter." The third criterion was ignored, since the hearing procedures were *not* fair to Dr. Tarabishi under the circumstances. App. at A-72.[9]

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[9] The Act does not preclude immediate suspensions or restrictions of clinical subject where the failure to act may result in an "imminent danger" to the health of any individual. While the Act is silent as to who is to determine whether such failure to act may result in "imminent danger," there was no intimation or discussion by the District Court or the Court of Appeals suggesting that an emergency existed. The evidence is to the contrary, since some of the alleged bases for revocation were actions that had occurred a year and a half before the actual revocation.

1. Failure to provide adequate notice and hearing

Under HCQIA, and the mandate of procedural due process, a physician against whom a professional review action is proposed should be notified of the proposal of such an action, the reasons for the action, and of his right to a hearing. Further, the physician must be given at least 30 days' notice to prepare for the hearing and a list of individuals who will testify.

The courts have held that failure to provide adequate notice to an affected physician before withdrawal of his privileges can constitute a due process violation. *Suckle v. Madison General Hospital,* 363 F.Supp. 1196 (W.D. Wis. 1973) (physician seeking reappointment given only a few minutes notice of his opportunity to meet with the committee which recommended his non-appointment; court found this was insufficient notice).

Here, the trial court explicitly found that Tarabishi was not given adequate notice of the hearing to be held, nor was he given the right to testify. The trial court took MRH and the other defendants to task for their failure to give adequate notice of a hearing and right to reply. Thus, it points out that "the Committee states that Dr. Tarabishi was invited to appear but 'declined to answer questions.' It is clear from page 216 that Dr. Tarabishi had only been provided with Dr. Boyer's letters ten minutes before the hearing began. Other instances could be cited. *The deficiencies in these peer review proceedings go far beyond a failure to observe 'procedural niceties,' as defendants seek to characterize them.*" [Emphasis supplied]. App. at A-71.

2. Failure to make a reasonable effort to obtain the facts of the matter

The District Court specifically noted that the Respondents here failed to interview key witnesses despite serious allegations against Dr. Tarabishi. The witnesses were not personally interviewed regarding the Darby case. The Committee merely read reports.

In fact, many of these allegations had arisen and been dropped, long before Tarabishi's clinic had been discussed. The "Darby" incident involved an alleged overdose of lidocaine on January 30, 1983, and was referred to various peer review committees, which, as of July 22, 1983, recommended no further action. On January 24, 1984, however, a "second investigation" of the Darby matter was opened, and between January and July of that year an investigatory committee, the Executive Committee, and the Review Committee issued reports and on July 18, 1984, "the governing body made its decision of revocation . . . Dr. Tarabishi's privileges were revoked." App. at A-52.

Despite the supposedly serious nature of the Darby incident, it took MRH more than 1-1/2 years from the incident and a "second investigation" to suspend Tarabishi's privileges – all, as the trial court pointed out, *without interviewing the key witnesses.*

Similarly, in the "Amber Weaver matter," where another MRH doctor reported that Tarabishi "had not seen and examined Amber Weaver prior to the time of surgery", App. at A-54, the trial court noted that the committee never bothered to talk to the patient's mother, but again relied on reports. App. at A-71.

In the "Ketcherside incident," Tarabishi as a member of the Surgery Committee asked the Executive Committee

to form an ad hoc committee, but the response of the Surgery Committee was to "vote unanimously to remove Tarabishi from the committee or suspend him until he 'prove[d] himself innocent' of charges" – a shift in the usual burden of proof and presumption of innocence. App. at A-52-A-53. Again, the trial court found that "although Mrs. Ketcherside contradicted Dr. McCauley's account, she was not directly talked with by the Committee." App. at A-71.

3. Failure to hold hearing before an impartial hearing officer

Under the HCQIA, the hearing must be held before a hearing officer or other appointed individuals who are not economic competitors.[10] The physicians and others conducting the "peer review" in Tarabishi failed to comply with the requirement that peer review be conducted "before an arbiter mutually acceptable to the physician and the health care entity." 42 U.S.C. sec. 11112(b)(3)(A)(1).

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[10] The legislative history indicates that the Committee placed a high priority on ensuring "that reviews of physicians pertain only to quality of care," and that even in small hospitals or in rural areas, "the Committee expects the professional review body to make every reasonable effort to find appropriate officers or members of the panel, *even if this requires bringing in reviewers from out of town or using physicians of a different specialty.*" [Emphasis supplied]. H.R. Rep. No. 99-903, 99th Cong., 2d Sess. 11 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6393.

As the District Court summarized it:

> "Tainting the entire process was the personal animus of many of the defendants toward Dr. Tarabishi. In one breath, a defendant doctor in this trial would testify that he virtually despised Dr. Tarabishi; in the next, he would testify that he could be and was 'fair and impartial' while sitting in judgment. These assertions of objectivity are, quite simply, not credible. It was made clear to the Court that many of the defendant doctors would have taken Dr. Boyer's word over Dr. Tarabishi's in any circumstance. *The Court cannot, by any rational definition of the term, 'approve' the peer review proceedings under review.*"

[Emphasis supplied]. App. at A-71-A-72.

II. THIS CAUSE SHOULD BE REVERSED AND REMANDED.

A. THE PER SE RULE SHOULD HAVE BEEN APPLIED BY THE LOWER COURTS.

In *Silver v. New York Stock Exchange*, 373 U.S. 341 (1963), the Court recognized the necessity of complying with the "fair hearing" requirement where an industry is given the right to engage in self-regulation. In *Silver*, broker-dealers in non-listed securities, acting under the direction of the New York Stock Exchange, refused to authorize private line connections between their officers and that of plaintiff Silver, although those connections were mandatory in order to enable Silver to transact business. The Court held that the action was a *per se* violation of the antitrust laws, despite the lack of any evidence that exclusion of Silver would injure competition market-wide. While the Securities Exchange Act of

1934, 15 U.S.C. sec. 78(b), had conferred a limited anti-trust exemption in accordance with the Exchange's self-regulatory duties, that exemption was held to extend no further than necessary to make the 1934 Act "work, and even then only to the minimum extent necessary." *Silver,* 373 U.S. at 357.

The Court began its analysis by assuming that the removal of Silver's wires "by collective action of the Exchange and its members would, had it occurred in a context free from other federal regulation, constitute a *per se* violation of sec. 1 of the Sherman Act." *Silver,* at 357. In the *Silver* situation, the Court held that the Exchange had exceeded this limit because it had given the plaintiff no notice of the reasons for its action, and no opportunity for a hearing at which to explain or refute the charges against him. The Court gave two reasons for this procedural requirement: the need to keep anti-competitive motives from controlling self-regulatory decisions, and the need to provide any reviewing court or other body with evidence of the purposes and motives of those self-regulatory decisions. 373 U.S. at 361, 363.

The Court specifically stated: "Our decision . . . holds that . . . [the] statute affords no justification for anti-competitive collective action taken without according fair procedures." 373 U.S. at 364. Nor was the Court interested in the justifications that the Exchange attempted to offer, finding that "nothing absent a partial or complete statutory exemption could justify a conventional boycott." *Silver,* at 365.

Procedural safeguards are a prerequisite to the validity of self-regulatory refusals to deal, and that principle was recognized in *Silver.* That principle was codified by Congress in the 1986 Health Care Quality Improvement

Act, which mandates procedural protection for those physicians denied privileges by peer review proceedings.

Here, there was simply no excuse not to afford petitioners "fair procedure." The alleged incidents leading to the revocation of Tarabishi's privileges occurred over a period of one and one-half years; no harm to the public requiring "emergency" revocation was even hinted.

Both the District Court and Court of Appeals chose to rely on *dictum* in one Third Circuit case and its progeny for the holding that a *per se* boycott analysis can never apply to a hospital staff privilege case where the hospital defends based on lack of professional ability. App. at A-69, A-23-A-24. In the case of *Weiss v. York Hospital*, 745 F.2d 786 (3rd Cir. 1984) *cert. denied*, 470 U.S. 1060 (1985), the Third Circuit in fact applied the *per se* rule and held that a hospital and individual physicians had engaged in a policy of unfair, unequal and unreasonable procedures in reviewing applications of osteopaths to hospital staff privileges.

In *Weiss*, the plaintiff, an osteopath who was denied staff privileges at York hospital, filed suit both individually and as class representative. The jury found that the defendants had engaged in a policy of discrimination against the plaintiff and other osteopaths. The Third Circuit concluded that the hospital's restrictive policy with respect to hospital staff privileges was sufficiently close to a traditional boycott, and thus the boycott characterization was appropriate. 745 F.2d at 820. The Hospital offered no "public service or ethical norm" rationale for the discriminatory treatment of osteopaths.

The District Court below also relied on *Pontius v. Children's Hosp.*, 552 F.Supp. 1352, 1369-70 (WD Penn 1987) (refusing to apply normal *per se* boycott rules,

derived from what the Court called the "normal commercial sphere," to peer review activities). In its review, the lower Court appeared to rely upon "public policy" as a justification for this same ultimate conclusion.

The lower courts' failure to apply a *per se* analysis merely because hospital peer review decisions are involved is:

(1) contrary to Supreme Court precedent;
(2) contrary to the intent of Congress expressed in HCQIA; and
(3) violates procedural due process.

B. PEER REVIEW PROCEEDINGS ARE NOT EXEMPT FROM THE PER SE APPROACH.

In its most elemental sense, plaintiff's suit accused defendants of conspiring by use of sham peer review proceedings to deprive Dr. Tarabishi of the use of the McAlester Regional Hospital, an essential facility to his practice as a surgeon, with full knowledge that his ability to compete with them would thereafter be destroyed. In its limited discussion of the peer review procedure, the Court below not only appeared to "exempt" peer review from *per se* analysis, but arguably, to exempt peer review proceedings from the application of the antitrust laws themselves on a "public policy basis." In footnote 14 of its opinion (Appendix 22) the Court cited its previous decision in *McKenzie v. Mercy Hospital,* for the proposition that "for public policy reasons, the essential facilities doctrine is inapplicable to hospital staff privileges decisions." It stated:

> "[T]his Court is in full agreement with the consistent decisions of other courts not to apply the essential facilities doctrine to exclusive service

> contracts by hospitals * * * To the extent that the plaintiffs argue the defendants conspired to deny them access to an essential facility in violation of Section 1, we would hold as this Court did in *McKenzie v. Mercy Hospital* of that plaintiffs were not denied an essential facility. * * * As for Dr. Tarabishi himself, his argument that he was denied an essential facility proves too much, for it amounts to an argument that a hospital can never deny a physician staff privileges, because restricting the practice of that physician always, in some sense, reduces competition." Footnote 14, Appendix A 23-24.

The foregoing is flawed, we submit, because nowhere, to our knowledge, has Congress articulated such a "public policy." Furthermore, one might logically inquire why, if "public policy" already *precluded* application of strict antitrust standards to peer review decisions, would Congress have granted immunity from the antitrust laws in the Health Care Quality Improvement Act, to those doctors following the due process provisions of the Act in the conduct of peer review? There is no private cause of action provided, for the violation of the Act, leaving an injured person with whatever remedies are provided for elsewhere in the law. The most obvious remedy for the type of injury occasioned by an illegal boycott is found in the antitrust laws. Obviously, we believe no such "public policy exemption" from the application of the antitrust laws exists for abuses of the self-regulating peer review procedures in the medical profession.

This Court has *never* used a more lenient standard when applying the antitrust laws to the professions, despite comments regarding the "public service and ethical norms" intrinsic to the professions. *See, Arizona v.*

Maricopa County Medical Society, 457 U.S. 332 (1982); *Goldfarb v. Virginia State Bar,* 421 U.S. 773, 788 n. 17 (1975); *National Society of Professional Engineers v. United States,* 435 U. S. 679, 696 (1978).

This Court has explicitly stated that the novelty of a maximum fee system and the lower courts' lack of experience in the medical antitrust area were not adequate reasons to apply the rule of reason when price-fixing was involved. *Arizona v. Maricopa County Medical Society,* 457 U.S. 332 (1982), found a violation of Section 1 of the Sherman Act when "competing physicians" set, by majority vote, "the maximum fees that they claim in full payment for health services provided to policyholders of specific insurance plans." 457 U.S. at 345. The Court in *Maricopa* noted that "[t]he price fixing agreements in this case . . . are not premised on public service or ethical norms."

The test is *not* whether the industry involved happens to be the medical one, but whether the test laid down in *Silver* to permit the application of rule of reason have been met. Later courts have interpreted *Silver* as allowing the application of the rule of reason to concerted refusals to deal only if:

> (1) there is a legislative mandate for self-regulation or otherwise;
>
> (2) the action is intended to (a) accomplish an end consistent with the policy justifying self-regulation, (b) is reasonably related to that goal, and (c) is no more exclusive than necessary, and
>
> (3) the [defendant] provides procedural safeguards which assure that the restrain is not arbitrary and which furnishes a basis for judicial review." *Denver Rockets v. All-Pro Management,* 325 F. Supp. 1049, 1064-65 (C.D.Cal. 1971);

McCreery Angus Farms v. American Angus Ass'n, 379 F. Supp. 1008, 1018 (S.D. Ill. 1974).[11]

C. THIS CAUSE SHOULD BE CONSIDERED UNDER THE RULE OF REASON.

Should this Court find that a *per se* analysis is unsuitable here, the Rule of Reason approach to the treatment accorded Dr. Tarabishi here by Defendants should be applied. There is sufficient evidence to find an unreasonable restraint of trade under the doctrine of *Board of Trade of the City of Chicago v. United States*, 246 U.S. 231 (1918). The question in *Board of Trade* is "whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." 246 U.S. at 238.

In the past, this Court has evaluated challenged restraints by weighing the anticompetitive character of the restraint against the purported procompetitive effect. *FTC v. Indiana Federation of Dentists*, 476 U.S. 447 (1986); *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978); *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284 (1985).

Tarabishi has alleged an agreement among the defendants, who are all direct competitors, to eliminate any ear, nose and throat specialty competition for the defendant Clinic by terminating Tarabishi's hospital privileges, eliminating the *only* outpatient surgery competition of

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[11] In *McCreery*, a boycott of cattle breeders was held *per se* invalid because excluded breeders were not given advance notice that the association was reviewing their actions, adequate opportunity to respond to the charges against them or an opportunity to confront their accuser. 379 F.Supp. at 1018.

MRH, and preserving the status quo of stabilized and artificially high prices for medical services.

As in *Indiana Federation of Dentists,* the anticompetitive character of the restraint defendants have imposed here is obvious. Through the guise of "peer review" proceedings, defendants engaged in conduct which effectively "limit[ed] consumer choice by impeding the 'ordinary give and take of the market place' "; *Indiana Federation of Dentists,* 476 U.S. at 447, 458-59, quoting from *National Society of Professional Engineers v. United States,* 435 U.S. at 692. The Court below, instead of applying the "obvious injury to competition" test called for by the holding in *Indiana Dentists,* instead approved the District Court's finding of a lack of proof of injury to competition, even though the appeals court, *itself,* observed elsewhere in its opinion that a hospital's use of the peer review process to eliminate a physician "always, in some sense, reduces competition." Footnote 14, App. A-23 – A-24. Here, it eliminated the *only* competition.

The Court of Appeals gave defendants more than the benefit of the doubt by ruling that the termination of Dr. Tarabishi's privileges had "ostensibly" been based on "a lack of professional competence or unprofessional conduct." App. at A-29, n. 18. That finding is inconsistent with the finding of the District Court that the peer review actions against Dr. Tarabishi were a sham, not taken "in the reasonable belief that the action was in the furtherance of quality health care," but rather to further the Respondents' own economic motives.

III. CONCLUSION

There are important reasons for which the Supreme Court should grant this Petition for a Writ of Certiorari. Principal among those is the need for this Court to establish a uniform standard to deal with those elements of the medical profession who are engaged in the peer review process, and who chose, for whatever reason, *not* to follow the due process standards set forth in the Health Care Quality Improvement Act – and thereby fail to fall within its antitrust immunity provisions. Under such circumstances, what *is* the antitrust standard to be applied to admittedly joint conduct among professional medical competitors? Does the undefined "public policy" hinted at by the Court below preclude application of established antitrust standards to those peer review proceedings which, quite literally, shred due process? Under what authority? Are medical doctors different for antitrust immunity purposes, than are trade unions when they operate outside the scope of the antitrust immunity afforded them under the National Labor Relations Act, and thereby violate the antitrust laws? Is there a particular reason for which medical doctors, engaged in joint action peer review, should be treated differently, for purposes of antitrust immunity, than state government entities when they act outside the scope of state action immunity to violate the antitrust laws? In those instances, public policy does not preclude suit, and the full application of established antitrust standards, against State Government and Trade Unions.

What is the consequence of a group decision to violate the due process provisions of the HCQIA? Are standard antitrust remedies precluded? On a "public policy" basis as suggested by the Court of Appeals? If the *per se*

analysis is to be abandoned, and this Court's teaching in *Silver* and its progeny is to be disregarded for the medical profession, it would best serve the public interest for such new standard to be enunciated by *this* Court.

The anticompetitive conduct in the case at bar *commenced* when Dr. Tarabishi, speaking as the newly elected president of the Pittsburg County Medical Society, complained in a newspaper interview about the high cost of medical services which prevailed in the McAlester area, and suggested a need in the community for some type of competing facility. That competing facility was ultimately built. Unfortunately, long before the trial of this case concluded, its competitive influence had been eliminated, and the people of McAlester were once again relegated to a "one doctor, one hospital" process.

There may not ever be a better case, *factually,* from which this Court can determine the antitrust consequences flowing from a decision by a group of medical doctors to subvert the peer review process for the purpose of eliminating a competitor – here, the *only* other competitor in the area. This Court, and no other, should decide what consequences flow from a violation of Section 1 under factual circumstances where the immunity provisions of the HCQIA do not provide immunity from the application of the antitrust laws. We believe this Court should reaffirm the application of the *per se* standard called for in *Silver,* to abuses of the self-regulating aspect of the medical profession.

For all of the foregoing reasons Petitioner respectfully requests this Court to grant the Petition for a Writ of *Certiorari* and reverse the decision of the Court of Appeals for the Tenth Circuit.

Respectfully submitted,

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M. Hisham Tarabishi, M.D.

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APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

M. HISHAM TARABISHI,

Plaintiff-Appellant,

v.

MCALESTER REGIONAL HOSPITAL, also known as McAlester Regional Health Center Authority Public Trust Status; THE MCALESTER CLINIC, INC.; LEROY M. MILTON, M.D.; GEORGE BROWN, M.D.; WILLIAM G. BLANCHARD; SAMUEL E. DAKIL, M.D.; JOHN B. COTTON, M.D.; STEVEN ATWOOD, M.D.; CHARLES K. HOLLAND, M.D.; KARL SAUER, M.D.; HERTZL V. SCHAFF, M.D.; JOE MCCAULEY, M.D., and; DON SCHULLER, M.D.,

Defendants-Appellees.

No. 89-7056

ORDER

Filed January 24, 1992

Before ANDERSON, BALDOCK, Circuit Judges, SAM, District Judge.

This matter comes on for consideration of appellant's petition for rehearing filed in the captioned cause.

Upon consideration whereof, the petition for rehearing is denied.

Entered for the Court
ROBERT L. HOECKER, Clerk

By: /s/ Patrick Fisher
Patrick Fisher
Chief Deputy Clerk

M. Hisham TARABISHI, M.D., and M. Hisham Tarabishi, Inc., individually and doing business as TMD Out-Patient Medical Center and Tarabishi Medical Center, Plaintiffs-Appellants, Cross-Appellees,

v.

McALESTER REGIONAL HOSPITAL, also known as McAlester Regional Health Center Authority Public Trust Status; the McAlester Clinic, Inc.; Leroy M. Milton, M.D.; George Brown, M.D.; William G. Blanchard; Samuel E. Dakil, M.D.; John B. Cotton, M.D.; Steven Atwood, M.D.; Charles K. Holland, M.D.; Karl Sauer, M.D.; Hertzl V. Schaff, M.D.; Joe McCauley, M.D.; and Don Schuller, M.D., Defendants-Appellees, Cross-Appellants.

Nos. 89-7056, 89-7063.

United States Court of Appeals,
Tenth Circuit.

Dec. 10, 1991.

Physician brought antitrust action against hospital, clinic and other physicians arising out of termination of his medical staff privileges at hospital. Defendants prevailed on all claims except immunity claim, following trial in the United States District Court for the Eastern District of Oklahoma, H. Dale Cook, J., and appeal and cross appeal were taken. The Court of Appeals, Stephen H. Anderson, Circuit Judge, held that: (1) Oklahoma public trust hospital was not a special function governmental unit for purposes of antitrust immunity under the Local Government Antitrust Act of 1984; (2) failure to prove that hospital had evidenced monopoly power in its pricing was fatal to monopolization claims against hospital;

(3) for purposes of claims of monopolization and attempt to monopolize against clinic, physician failed to prove relevant markets or clinic's ability to exclude competition and control price; and (4) physician failed to prove claims of conspiracy to monopolize and conspiracy in restraint of trade.

Affirmed.

Frank Gregory, Tulsa, Okl. (James C. Lang, Kevin C. Leitch, and G. Steven Stidham of Sneed, Lang, Adams, Hamilton & Barnett, Tulsa, Okl., with him on the briefs), for plaintiffs-appellants, cross-appellees.

George F. Short of Short, Barnes, Wiggins, Margo & Alder, Oklahoma City, Okl., for defendant-appellee, cross-appellant McAlester Regional Medical Hosp.

Douglas J. Colton of Verner, Liipfert, Bernhard, McPherson & Hand, Chartered, Washington, D.C. (Kevin Driskill and Cynthia L. Sparling of Short, Barnes, Wiggins, Margo & Alder, Oklahoma City, Okl, Joe Stamper of Stamper, Otis & Burrage, Antlers, Okl., for defendant-appellee, cross-appellant McAlester Regional Medical Hosp., Joseph F. Glass and Leigh Reaves of Thomas, Glass, Atkinson, Haskins, Nellis & Boudreaux, Tulsa, Okl., for defendants-appellees, cross-appellants McAlester Clinic and individuals, with them on the briefs), for defendants-appellees, cross-appellants.

Before ANDERSON, BALDOCK, Circuit Judges, and SAM,* District Judge.

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*Honorable David Sam, United States District Court for the District of Utah, sitting by designation.

STEPHEN H. ANDERSON, Circuit Judge.

Plaintiffs-appellants and cross-appellees, Dr. M. Hisham Tarabishi, M.D., and M. Hisham Tarabishi, Inc., appeal an adverse judgment following a nine-week trial to the court on plaintiffs' antitrust claims arising out of the termination of Dr. Tarabishi's medical staff privileges at defendant McAlester Regional Hospital. We affirm.

BACKGROUND

Dr. Tarabishi is an ear, nose and throat doctor who practiced medicine in McAlester, Oklahoma from 1979 to 1985. M. Hisham Tarabishi, Inc. was an Oklahoma professional corporation whose sole shareholder was Dr. Tarabishi. Defendant McAlester Clinic, Inc. is an Oklahoma professional corporation composed at the time relevant to this case of approximately 17 or 18 shareholder physicians with a wide range of medical specialties. Defendant Hospital is a 200-bed facility located in McAlester, Oklahoma. It was established as a public trust hospital under Okla.Stat. tit. 60, §§ 176-180. Its beneficiary is the City of McAlester. It is the only hospital in McAlester, formed by the merger of two preexisting hospitals. Other individual defendants are physicians, most of whom were members of the Clinic at the time relevant to this case, and a few of whom were not.[1] All had staff privileges at the Hospital.

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[1] The individual defendants are as follows, with their area of medical specialty as indicated: Leroy Milton, M.D. (internal medicine); George Brown, M.D. (general surgery); William Blanchard, M.D. (general surgery); Samuel Dakil, M.D. (ear,

(Continued on following page)

Dr. Tarabishi joined the Clinic in 1979. Prior to that, he had practiced in Marshfield, Wisconsin, after completing his medical training at several different locations. He was granted full staff privileges at the Hospital when he began practice with the Clinic. After six months, differences apparently developed between Dr. Tarabishi and the Clinic concerning aspects of his employment, compensation and pension. The Clinic decided to terminate his employment, which it formally did in January, 1980. Dr. Tarabishi thereupon opened his own medical practice consisting of some general surgery, some ear, nose and throat surgery, and an office medical practice. His practice was, by all accounts, successful.

In 1982, Dr. Tarabishi explored the possibility of establishing an outpatient surgical clinic, to be called the TMD Center, which would have been the first such clinic in McAlester. He commissioned a feasibility study to examine whether such a clinic was needed. The study indicated the planned outpatient surgical clinic would be economically feasible.

(Continued from previous page)

nose and throat); John Cotton, M.D. (family practice); Steven Atwood, M.D. (internal medicine/emergency medicine); Charles Holland, M.D. (internal medicine); Karl Sauer, M.D. (general surgery); Joe McCauley, M.D. (family practice); and Don Schuller, M.D. (radiology). Defendants Milton, Brown, Blanchard, Dakil, Cotton, Atwood and Holland were members of the Clinic. Additionally, Milton and Holland were both members of the Hospital's Board of Trustees during the time relevant to this case. In May 1984, Milton became "Chief of Staff" at the Hospital. Defendants Sauer, Schaff, McCauley and Schuller were not affiliated with the Clinic. Plaintiffs named as non-defendant co-conspirators four other doctors who practice at the Hospital.

In accordance with applicable Oklahoma law, Dr. Tarabishi prepared a Certificate of Need application so that his planned new facility would be appropriately licensed by the Oklahoma Health Planning Commission. He retained a health care industry consultant, Mr. Jerry Colclazier, to assist him in preparing the Certificate of Need application. In connection with that application, Mr. Colclazier conducted his own investigation of the need for an outpatient surgical clinic of the sort Dr. Tarabishi envisioned, as well as of Dr. Tarabishi's qualifications. After concluding that such a clinic was needed, and that Dr. Tarabishi had the capability of establishing and operating one, he prepared the Certificate of Need application, which was completed and filed on March 14, 1983.

In connection with the Certificate of Need application, Dr. Tarabishi sought from the Hospital a statement of neutrality regarding the application. The Hospital never adopted any such position of neutrality. It did, however, inform Dr. Tarabishi twice that its position was that it had no interest in the medical practice of a physician conducted in his own office.

At a February 1983 meeting of its Board of Trustees, the Hospital decided to open its own outpatient surgical department, to be opened on April 1, 1983. The minutes of a May 1983 meeting of the Hospital Board reflect that the Board then determined to oppose Dr. Tarabishi's Certificate of Need application, on the ground that the proposed facility would duplicate the hospital's surgical services. Among those speaking against his application at hearings before the Oklahoma Health Planning Commission were Ed Majors, the Administrator of the Hospital, Gary Brock, at that time the Assistant Administrator, Tom

Giandrone, the Comptroller, and Dr. Leroy Milton, then a shareholder of the clinic and a member of the Board of Trustees of the Hospital. Hospital Administrator Ed Majors argued that the proposed facility "would hurt MRH [the hospital] financially, by costing the Hospital substantial sums, including approximately $387,500 during the first year, $432,800 the second year and $472,000 the third year of TMD's operations." District Court Findings of Fact and Conclusions of Law at 13 (citing Plaintiffs' Ex. 25(a) at 5). The Certificate of Need was in fact granted in June 1983.

Meanwhile, the Hospital, as planned, opened up its own outpatient ambulatory surgical department in April, 1983, accompanied by an increased advertising campaign featuring, in part, the new department. During this same time frame – i.e. from April to June of 1983 – the Hospital initiated several investigations into incidents involving alleged patient and case mismanagement and other improper or inappropriate behavior by Dr. Tarabishi. These resulted in investigations by various committees and boards between June 1983 and July 1984.

On May 24, 1984, the Hospital revoked Dr. Tarabishi's surgical and emergency room privileges, which meant that Dr. Tarabishi could no longer treat his patients in the Hospital's emergency room, nor could he perform surgery at the Hospital. The Hospital revoked all of Dr. Tarabishi's staff privileges on July 17, 1984, with the result that he could no longer use Hospital facilities for any purpose.

The TMD Center was finally completed in July, 1984. The Center commenced operation on July 9, 1984 and

continued to operate until August 31, 1985, at which time it ceased operation and Dr. Tarabishi stopped practicing medicine in McAlester. Apparently, Dr. Tarabishi has since tried to resume his practice in Pennsylvania, but has been unable to obtain hospital privileges, due, in part, to the revocation of his privileges in McAlester by the Hospital.

The reasons for TMD's failure are disputed. Defendants assert that its economic structure was flawed from the beginning. Plaintiffs assert that it was the revocation of Dr. Tarabishi's staff privileges which caused the failure. As the district court found, a condition for the Oklahoma Planning Commission's grant of a license to the TMD Center was that TMD have access to the Hospital's emergency care facilities. This was because the Center was not equipped to deal with complex medical or surgical problems. Patients at the Center therefore needed access to the Hospital's facilities in the event that a complication or emergency developed. While Dr. Tarabishi had full medical staff privileges at the Hospital, the TMD Center complied with that condition. Upon the revocation of Dr. Tarabishi's Hospital staff privileges, TMD failed to be in compliance with that condition. However, in November 1984, Dr. Tarabishi and the Hospital entered into a "transfer agreement" pursuant to which TMD patients could be admitted to the Hospital if an emergency developed. Dr. Tarabishi could not, however, continue himself to treat patients after they were transferred to the Hospital. In any event, Dr. Tarabishi closed the TMD Center in August, 1985.

Dr. Tarabishi then brought this action, alleging a host of antitrust violations by defendants. Among defendants'

affirmative defenses was immunity from the antitrust laws under the "state action" doctrine of *Parker v. Brown*, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943), and subsequent cases, and under the Local Government Antitrust Act of 1984, 15 U.S.C. §§ 34-36.[2] After a nine-week trial to the court, defendants prevailed on all claims but their immunity claim. Plaintiffs timely appealed and defendants cross-appealed on the immunity issue.[3]

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[2] Defendants do not appear in this appeal to argue they are entitled to state action immunity.

[3] There is a pending motion to dismiss the cross-appeal for failure to file it timely. The facts relating to this motion are as follows: Under Fed.R.App.P. 4(a)(3) the notice of cross-appeal was due on June 19, 1989. In fact, it was filed on June 20. Upon learning that it had been filed late, defendants/cross-appellants filed a motion for extension of time in which to file the notice. Included was an affidavit from defendants' counsel, which stated that the notice had been mailed to Muskogee, Oklahoma from Tulsa, Oklahoma on June 16, and that in counsel's experience mail between those two cities took at most two days. Defendants also relied upon Fed.R.App.P. 4(a)(5), asserting that their late filing was due to "excusable neglect." Plaintiffs/cross-appellees filed a response arguing that the "excusable neglect" standard had not been met in this case and defendants filed a reply. The district court granted defendants' motion for an extension of time, applying it *nunc pro tunc* to the notice of appeal filed June 20. We review that conclusion only for a clear abuse of discretion. *See Harris Truck Lines, Inc. v. Cherry Meat Packers, Inc.*, 371 U.S. 215, 83 S.Ct. 283, 9 L.Ed.2d 261 (1962); *Romero v. Peterson*, 930 F.2d 1502, 1505 (10th Cir. 1991).

Plaintiff/cross-appellees first argue that the district court applied the wrong standard by inquiring whether defendants

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DISCUSSION

We first consider the Hospital's and individual defendants' claim that the district court erred in finding they were not immune from the application of the antitrust laws under the Local Government Antitrust Act of 1984 ("LGAA"), 15 U.S.C. §§ 34-36.

The LGAA provides that "[n]o damages, interest on damages, costs, or attorney fees may be recovered under § 15, § 15(a) or § 15(c) of this Title from any local government, or official or employee thereof acting in an official capacity." 15 U.S.C. § 35(a). "Local government" is defined to include "a school district, sanitary district, or any other special function governmental unit established by State law." 15 U.S.C. § 34(1)(B). The Hospital claims

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demonstrated "good cause" rather than "excusable neglect." We disagree. An examination of the district court's order makes it clear that the court applied the "excusable neglect" rather than the "good cause" standard.

More importantly, the motion to dismiss requires us to decide whether the district court properly found excusable neglect in the circumstances of this case. Noting the broad discretion granted the district court in making that determination, we deny the motion to dismiss the cross-appeal. In denying the motion, however, we remind the parties that we would still consider the issue raised in the cross-appeal – whether defendants had any immunity from the application of the antitrust laws – because defendants may raise any ground for upholding the favorable judgment they received below. *See In re Robinson*, 921 F.2d 252, 253 (10th Cir.1990); *Koch v. City of Hutchinson*, 847 F.2d 1436, 1441 n. 14 (10th Cir.) (en banc), *cert. denied*, 488 U.S. 909, 109 S.Ct. 262, 102 L.Ed.2d 250 (1988).

immunity as a "special function governmental unit" and the individual doctors as employees or agents of that unit. The district court denied motions by the Hospital and the doctors for summary judgment on plaintiffs' claims for damages, concluding that, although it was a public trust hospital, the Hospital was not a "special function governmental unit" under the LGAA. It reiterated that conclusion in its final Findings of Fact and Conclusions of Law. We affirm.

The LGAA was enacted to give greater immunity to local governments. It was a legislative response to "an increasing number of antitrust suits, and threatened suits, that could undermine a local government's ability to govern in the public interest." H.R.Rep. No. 965, 98th Cong., 2d Sess. 2, *reprinted in* 1984 U.S.Code Cong. & Admin. News 4602, 4603; *see also Sandcrest Outpatient Servs., P.A. v. Cumberland County Hosp. Sys., Inc.*, 853 F.2d 1139, 1142 (4th Cir.1988). As indicated, the Act specifically provides that school districts and sanitary districts are special function governmental units entitled to immunity. The legislative history of the Act suggests others: planning districts, water districts, sewer districts, irrigation districts, drainage districts, road districts, and mosquito control districts. *Id.* at 4620-21.[4] Hospitals, whether public trust hospitals or otherwise, are not specifically mentioned. Several courts have noted, however, that the

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[4] The list of other types of units entitled to immunity actually comes from the House Report on the predecessor bill to the Act, which had defined "local government" as a "city, county, parish, town, township, village, school district, sanitary district, or any other general or special purpose political subdivision of one or more States."

Act is to be construed broadly. *See Palm Springs Medical Clinic, Inc. v. Dessert Hosp.*, 628 F. Supp. 454 (C.D.Cal. 1986) (the court noted that "[t]he language of the 1984 Act is inclusive and not exclusive, defining a 'local government' as 'a school district, sanitary district, or *any other special function governmental unit* established by State law in one or more States.' " *Id.* at 456 n. 2; *see also Capital Freight Servs., Inc. v. Trailer Marine Transp. Corp.*, 704 F.Supp. 1190, 1198 (S.D.N.Y.1989) ("the language and legislative history of the LGAA is explicitly inclusive, not exclusive."). Further, we agree with the observation of the court in *Capital Freight Servs.*, that Congress "rejected the commercial-governmental distinction, adopting a definition for eligibility for immunity based on status as a governmental instrumentality and effect on taxpayers rather than purpose." *Id.* at 1199.

Defendants assert that our recent decision in *Buckley Constr., Inc. v. Shawnee Civic & Cultural Dev. Auth.*, 933 F.2d 853 (10th Cir.1991), establishes the Hospital's immunity under the LGAA. Defendants further assert that the purpose of the LGAA was to permit local government entities to go about their business free of the threat of large antitrust damage awards, and that an award against the Hospital would obviously hurt McAlester. Finally, they rely upon a handful of cases holding that, under the laws of different states, certain hospitals were held to be special function governmental units.[5] Defendants assert

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[5] *See Sweeney v. Athens Regional Medical Ctr.*, 705 F.Supp. 1556, 1561-62 (M.D.Ga. 1989); *Griffith v. Health Care Auth. of the City of Huntsville*, 705 F.Supp. 1489, 1501 (N.D.Ala.1989); *Wicker v. Union County General Hosp.*, 673 F.Supp. 177, 186 (N.D.Miss. 1987); *Palm Springs Medical Clinic, Inc. v. Desert Hosp.*, 628 F.Supp. 454, 456-57 (C.D. Cal. 1986).

that these facts bring the Hospital within the definition of a special function governmental unit for purposes of the LGAA.

Plaintiffs respond that Oklahoma law controls the question here, and thus the interpretation of the status of a hospital under the laws of other states is immaterial. further, the mere fact that a judgment against the Hospital would hurt McAlester does not mean that the Hospital is a special function governmental unit with antitrust immunity. Finally, plaintiffs rely upon the fact that under the provisions of the Governmental Tort Claims Act, Okla.Stat. tit. 51, §§ 151, *et seq.*, then in effect, public trusts operating hospitals were specifically excluded from the definition of "political subdivision" under that Act. In 1987, however, the Governmental Tort Claims Act was amended to specifically include public trusts operating hospitals within the definition of political subdivisions.

Defendants' reliance on *Buckley Construction* is misplaced. In *Buckley*, the plaintiff, a disappointed low bidder on a construction contract, alleged that one of the defendants, Shawnee Civic & Cultural Development Authority, had violated the antitrust laws in its award of the contract to the second lowest bidder on the project. While the Authority was indeed a public trust created pursuant to the same Oklahoma statutes which created the Hospital in this case,[6] its challenged conduct was

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[6] The Hospital was formed as a trust for furtherance of public functions under 60 Okla.Stat. §§ 176-180. The City of McAlester owns the land upon which the Hospital is located and leases it to the Hospital. Its trustees are public officers,

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undertaken pursuant to provisions of the Oklahoma Public Competitive Bidding Act, Okla.Stat. tit. 61, §§ 101-136. Those provisions were the ones relevant to the question of state action immunity under *Parker v. Brown*, 317 U.S. 341, 342, 63 S.Ct. 307, 87 L.Ed. 315 (1943), and subsequent

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appointed by the mayor of McAlester, and they must take the oath of office required of elected public officials. 60 Okla.Stat. § 178(A). Meetings of the trustees are subject to the open meeting laws like other public boards and commissions. *Id.* at § 178(C). The Declaration of Trust which created the Hospital stated that the Hospital was created for the benefit of the city of McAlester and that the purpose of the trust was to provide hospital and public health services to the residents of McAlester. Defendants' Ex. 155D, Addendum of Appellees/Cross-Appellants at Tab D. However, as the district court noted, a public trust in Oklahoma is a separate legal entity from its beneficiary. *See State v. Garrison*, 348 P.2d 859, 863 (Okla. 1959). Hospital employees are *not* city employees. Further, as the district court also noted, 60 Okla.Stat. § 179 makes it clear that any judgment against the Hospital would be satisfied out of the trust estate, and the beneficiary (the city of McAlester) would not be liable.

Defendants also argue that in Dr. Tarabishi's section 1983 action against the Hospital and its trustees arising out of the same facts, this court held that the Hospital and its trustees were acting under color of state law for section 1983 purposes. *Tarabishi v. McAlester Regional Hosp.*, 827 F.2d 648, 652 (10th Cir. 1987). That determination is not, however, dispositive of whether the actions of the Hospital and its trustees are entitled to immunity as those of a special function governmental unit and its officials or employees. *Cf. Ezpeleta v. Sisters of Mercy Health Corp.*, 800 F.2d 119, 122 (7th Cir.1986) (per curiam) (even though antitrust claim is barred by state action doctrine, section 1983 claim is unavailable because there is no state action in decision to terminate physician's staff privileges).

cases.[7] Thus, the fact that this court in *Buckley* found the actions of a public trust in awarding a construction contract pursuant to applicable competitive bidding statutes immune under the state action doctrine says nothing about whether a public trust hospital should be immune under the LGAA.

Further, the cases from other jurisdictions upon which defendants rely are distinguishable. In *Sandcrest Outpatient Servs., P.A. v. Cumberland County Hosp. Sys., Inc.*, 853 F.2d 1139 (4th Cir.1988), involving a county hospital owned and operated by a nonprofit corporation created as an agency and instrumentality of the county, the plaintiff did not appeal the district court's conclusion that the nonprofit corporation which owned and operated the hospital was a governmental unit under the LGAA. Thus, the appellate court simply assumed that to be the case. *Palm Springs Medical Clinic, Inc. v. Desert Hosp.*, 628 F.Supp. 454 (C.D.Cal.1986), upon which defendants place great reliance, involved a hospital district created pursuant to California Health & Safety Code §§ 32000, *et seq.* After extensively examining the legislative history of the LGAA, the court concluded that the hospital district was immune.[8] In *Sweeney v. Athens Regional Medical Ctr.*, 705 F.Supp. 1556 (M.D.Ga. 1989), the court held, without

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[7] Immunity under the LGAA was apparently not an issue in *Buckley*.

[8] We note that recently, however, the Ninth Circuit has ruled that a hospital district is not immune under the state action doctrine, without specifically discussing immunity under the LGAA. *Lancaster Comm. Hosp. v. Antelope Valley Hosp. Dist.*, 940 F.2d 397 (9th Cir.1991).

specific analysis but simply "[a]fter considering the relevant statutory authority," that a public hospital authority organized under the Georgia Hospital Authorities Law was a local government unit under the LGAA.[9] *Id.* at 1562. Similarly, a district court in *Griffith v. Health Care Auth.*, 705 F.Supp. 1489, 1501 (N.D.Ala.1989) held that a health care authority was a "local government" under the LGAA.[10] Finally, in *Wicker v. Union County Gen. Hosp.*, 673 F.Supp. 177 (N.D.Miss.1987), a public hospital owned and operated by a county was held to be a governmental agency.[11] None of these cases directly answers the question of whether a hospital operated as a public trust for furtherance of public functions with a city as its beneficiary should be considered a special function governmental unit. *Cf. Zapata Gulf Marine v. P.R. Maritime Shipping Auth.*, 682 F.Supp. 1345, 1351 (E.D.La.1988) (court held

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[9] Under the applicable Georgia law, the authority "operates as a not-for-profit public corporation and is 'deemed to exercise public and essential governmental functions and shall have all the powers necessary or convenient to carry out and effectuate the purposes and provisions of [the Hospital Authorities Law].' " *Sweeney*, 705 F.Supp. at 1561 (quoting Ga.Code Ann. §§ 31-7-75, 77 (1985)).

[10] The health care authority was established pursuant to the Health Care Authorities Act of 1982, Ala.Code §§ 22-21-310, *et seq.*, which provided, *inter alia*, that such authorities "act[ ] as an agency or instrumentality of its authorizing subdivisions and as a political subdivision of the state." Ala.Code § 22-21-318(c)(2).

[11] The court held "the Hospital and its board [of trustees] are themselves governmental agencies. The trustees on the board are appointed to limited terms by elected representatives of the people." *Wicker*, 673 F.Supp. at 186.

that Puerto Rico Maritime Shipping Authority was special function governmental unit because statute creating it described it as a "governmental instrumentality of the Commonwealth of Puerto Rico," funds to cover an antitrust damage award against the Authority would come ultimately from the taxpayers, the creation and operation of the Authority "was necessitated by the inability of the private sector to meet the public's needs," and because the statute creating the Authority provided that the exercise of its powers "constitutes an essential governmental function."); *Trustees of A.J. Bremen Realty Trust v. City of Boston,* 1985-1 Trade Cas. (CCH) ¶ 66,520, 1985 WL 6083 (D.Mass.1985) (court held Massachusetts Port Authority was a special function governmental unit because created as a public instrumentality and because the exercise of its powers were deemed to be an "essential governmental function."); *Northeast Jet Ctr., Ltd. v. Lehigh-Northhampton Airport Auth.,* 767 F.Supp. 672, 680 (E.D.Penn. 1991) (airport authority is special function governmental unit).

After carefully examining the relevant statutes and case law, we hold that the district court correctly determined that the Hospital is not a special function governmental unit. No single factor is determinative. Rather, two considerations guide our decision.

First, we agree with the district court that a significant consideration is where liability for an antitrust damage award will actually fall, in light of the LGAA's obvious concern to limit the imposition of treble damage awards on taxpayers. In this case, the city of McAlester is the beneficiary of the public trust, and as such is clearly not liable for any damage award made against the trust.

Thus, the LGAA's concern about imposing unfair burdens on the taxpayers is not implicated.

Second, inasmuch as the question of the character of a local entity under the LGAA is a question of state law, we find it persuasive that around the time of the challenged conduct, the Oklahoma legislature clearly viewed public trust hospitals as entities different from political subdivisions. Indeed, under the provisions of the Governmental Tort Claims Act, Okla.Stat. tit. 51, § 152, immunity was granted to the "state, its political subdivisions, . . . whether performing governmental or proprietary functions. . . . " "Political subdivision" was thereafter defined as including a "municipality," a "school district," a "county," and "a public trust where a city, town school district or county is a beneficiary, provided, that for the purposes of this act, a public trust shall not include any hospital operating under a trust authority." *Id.* at 152(8). This clear exclusion suggests that the Oklahoma legislature at the time did *not* view public trust hospitals as entities comparable to municipalities, school district, or counties. While the Tort Claims Act's clear *inclusion* of public trust hospitals under its definition of political subdivisions since 1987 might suggest a different result today, we believe the former provisions indicate a conscious characterization of a public trust hospital under state law at the time relevant to this case.

Having affirmed the conclusion that defendants enjoy no immunity from damage claims under the LGAA, we turn to the merits of this case.

Plaintiffs alleged the following antitrust violations: (1) monopolization of surgical health care services by the

Hospital; (2) monopolization of and attempt to monopolize non-surgical and office health care services by the Clinic; (3) conspiracy to monopolize by all defendants; and (4) conspiracy in restraint of trade by all defendants. The district court rejected all those claims.

1. *Monopolization by Hospital.*

Plaintiffs allege the Hospital monopolized the surgical health services market.[12] Apparently, as a part of this claim, plaintiffs assert that the Hospital violated the "essential facilities" doctrine by means of the revocation of Dr. Tarabishi's staff privileges, thereby denying him access to the Hospital's facilities which he argues are crucial to his practice.

> The elements of monopolization under Section 2 are "the possession of monopoly power in the relevant market" and "the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident."

Reazin v. Blue Cross and Blue Shield, 899 F.2d 951, 973 (10th Cir.), *cert. denied*, ___ U.S. ___, 110 S.Ct. 3241, 111 L.Ed.2d 752 (1990) (quoting *Bright v. Moss Ambulance Serv.*, 824 F.2d 819, 823 (10th Cir. 1987) (quoting *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71, 86 S.Ct. 1698, 1703-04,

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[12] In their complaint and Amended Complaint, plaintiffs appeared to charge the Hospital with attempted monopolization as well. The district court did not address such a claim in its Findings of Fact and Conclusions of Law, and plaintiffs do not appear to pursue it in their appellate briefs.

16 L.Ed.2d 778 (1966))). In this circuit, proof of monopoly power requires a showing of both power to control prices and power to exclude competition. *Reazin*, 899 F.2d at 967; *Bright*, 824 F.2d at 824; *Shoppin' Bag of Pueblo, Inc. v. Dillon Cos.*, 783 F.2d 159, 163 (10th Cir.1986). Determination of the existence of monopoly power requires proof of relevant product and geographic markets.

The district court found error with plaintiffs' proof of markets. More specifically, the court found there was insufficient evidence to prove the asserted markets. These are factual findings subject to the clearly erroneous standard of review. *Westman Comm'n Co. v. Hobart Int'l, Inc.*, 796 F.2d 1216, 1220 (10th Cir.1986), *cert. denied*, 486 U.S. 1005, 108 S.Ct. 1728, 100 L.Ed.2d 192 (1988). Plaintiffs' expert, Dr. Joe Jadlow, testified that the relevant product market for the Hospital was the business of supplying surgical health care services. The relevant geographic market was defined as the area within a 30-mile radius of McAlester. The district court noted the following problems with the geographic market:

> First, the geographic radius was derived from an examination of MRH [Hospital] discharge records, and a finding that 84% of its discharged patients lived within thirty miles of McAlester. As was pointed out on cross-examination, plaintiffs' expert did not take into account whether patients who lived within the 30-mile radius went elsewhere than MRH for surgical health care services. The "time factor" which might keep patients close to home was not quantified.

District Court Findings of Fact and Conclusions of Law at 25. The district court also criticized Dr. Jadlow's use of a

bed count to measure the Hospital's market share in the market of surgical health care services.[13]

More fundamentally, the district court noted that plaintiffs simply failed to present any evidence about the Hospital's power to control prices, a critical element of proof of monopoly power in this circuit. *Reazin*, 899 F.2d at 967; *Shoppin' Bag of Pueblo*, 783 F.2d at 163. Indeed, as plaintiffs' expert, Dr. Jadlow, conceded, he had not examined whether the Hospital had evidenced monopoly power in its pricing. R. Vol. VI at 243, 249-50. Such a proof failure is fatal to plaintiffs' monopolization claims against the Hospital. Thus, we affirm the district court's conclusion that "a showing of monopoly power [by the Hospital] has not been made." District Court Findings of Fact and Conclusions of Law at 27. Plaintiffs' section 2 claims against the Hospital therefore fail.[14]

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[13] The district court stated "[t]he mere words of the plaintiffs' market definition denote more than the provision of a hospital bed." District court findings of Fact and Conclusions of Law at 25. The district court also concluded that Dr. Tarabishi, as a provider of surgery or surgical services to his patients, was neither a competing provider now a consumer of "surgical health care services." Similarly, the court concluded that TMD was neither a competitor nor a consumer in the market of surgical health care services, because TMD did not have beds, the measure by which the Hospital's market share in the surgical health care services market was determined.

[14] As indicated, plaintiffs argue mightily that the "essential facilities" doctrine was violated in this case. This court explored that doctrine in *McKenzie v. Mercy Hosp. of Independence*, 854 F.2d 365, 369 (10th Cir.1988):

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2. *Monopolization and Attempt to Monopolize by Clinic.*

To establish monopolization by the Clinic, plaintiffs must, as indicated, prove monopoly power. In their

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> Though the Supreme Court first employed the essential facilities doctrine to condemn the conduct of multiple defendants under Section 1 of the Sherman Act, the doctrine has since been applied in cases brought under Section 2 and in which only a single entity controls the necessary facility.
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> * * *
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> More recently, the federal courts of appeals have adopted standards to determine whether a monopolist's refusal to deal constitutes a violation of the essential facility doctrine under Section 2. In *MCI Communications Corp. v. American Tel. and Tel. Co.*, 708 F.2d 1081, 1132-33 (7th Cir.), *cert. denied*, 464 U.S. 891 [104 S.Ct. 234, 78 L.Ed.2d 226] (1983), the court held that to establish liability under the doctrine, the plaintiff must show: "(1) control of the essential facility by a monopolist; (2) a competitor's inability practically or reasonably to duplicate the facility; (3) the denial of the use of the essential facility to a competitor; and (4) the feasibility of providing the facility."

Id. at 369 (citations omitted). This court went on to note, however, that a district court had "declared that for public policy reasons, 'the essential facilities doctrine is inapplicable to hospital staff privileges decisions.' " *Id.* at 371 n. 12 (quoting *Pontius v. Children's Hosp.*, 552 F.Supp. 1352, 1370 (W.D.Pa.1982)). *See also Castelli v. Meadville Medical Ctr.*, 702 F.Supp. 1201, 1209 (W.D.Pa. 1988), *aff'd*, 872 F.2d 411 (3d Cir.1989) ("This court is in full agreement with the consistent decisions of other courts not to apply the essential facilities

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attempt to prove such power, plaintiffs' expert, Dr. Jadlow, defined the relevant product market as the business of supplying non-surgical and office surgery health care services. As with the Hospital, he defined the relevant geographic market as the area within a 30-mile radius of McAlester. He further opined that the Clinic had a 66% share of that market, based on the following analysis:

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doctrine to exclusive service contracts by hospitals."). The *McKenzie* court did not address that issue because it concluded that, even if the doctrine were to apply, the plaintiff had failed to show that he was denied access to an essential facility.

Were we to apply the doctrine to this denial of staff privileges case, we would hold that it fails as a section two claim because plaintiffs failed to establish that the Hospital or any other defendant is a monopolist. To the extent plaintiffs argue the defendants conspired to deny them access to an essential facility in violation of section one, we would hold as this court did in *McKenzie,* that plaintiffs were not denied an essential facility.

If we analyze the two plaintiffs separately, plaintiffs' failure to prove an essential facility becomes clearer. Plaintiffs themselves assert that it was the TMD Center which was the alleged primary competitive threat to defendants. For the TMD Center, however, *Dr. Tarabishi's* access to Hospital facilities was not essential, because in November 1984 the TMD Center and the Hospital entered into a transfer agreement pursuant to which TMD patients *had* access to the Hospital. As for Dr. Tarabishi himself, his argument that he was denied an essential facility proves too much, for it amounts to an argument that a hospital can never deny a physician staff privileges, because restricting the practice of that physician always, in some sense, reduces competition. Yet Dr. Tarabishi has not proved that restricting his own access to the Hospital, apart from the TMD Center, diminished competition in a meaningful antitrust sense.

> And I did this by looking to see what were the specialties of the physicians at the McAlester Clinic. I included those specialties in looking at the total number of physicians in the McAlester community, and I looked to see what proportion of that total group physicians the McAlester Clinic accounted for.

R. Vol. V at 24. The district court again noted the following problems with Dr. Jadlow's market determinations:

> While defining the geographic market as a 30-mile radius, plaintiffs' expert focused only on doctors within McAlester itself. he did not consider doctors within the radius who did not practice in McAlester. A recurring theme in his testimony was that he focused solely upon the Clinic and the City of McAlester. Dentists who perform root canal work, for example, while appearing to fall within the language of plaintiffs' product market definition, were excluded solely because plaintiffs' expert did not believe such surgery was done at the Clinic. Regarding the proposed geographic market, plaintiffs' expert at one point characterized it as an approximation. However, it is clear that the actual geographic area studied was the City of McAlester itself. In sum, both as to product market and geographic market, the procedure of plaintiffs' expert varied from the actual proposed markets.

District Court Findings of Fact and Conclusions of Law at 27-28. We cannot say that these findings are clearly erroneous.[15]

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[15] Plaintiffs make a multi-pronged attack on the district court's conclusions with respect to market definition. It is

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Further, again as with the monopolization claim against the Hospital, plaintiffs presented no evidence of the Clinic's ability to exclude competition and to control price.[16] Absent such proof, we are compelled to conclude

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difficult to respond to all aspects of this attack, because many of them are obscure. Suffice it to say that we bear in mind that it is *plaintiffs'* burden to prove relevant markets. Thus, plaintiffs' attack on defendants for "fail[ing] to show why medical care consumers from Pittsburgh County may sometimes travel to other locations" is beside the point. Further, proof of markets is required so that adverse impact on *competition* can be evaluated. Thus, plaintiffs' markets must bear some relation to plaintiffs' theory of harm to competition. Plaintiffs in this case have failed in that respect.

Plaintiffs belatedly attempt to remedy their failure to plead and prove relevant markets by citing *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447, 106 S.Ct. 2009, 90 L.Ed.2d 445 (1986), where the Supreme Court stated, " 'proof of actual detrimental effects, such as a reduction of output' can obviate the need for an inquiry into market power, which is but a 'surrogate for detrimental effects.' " *Id.* at 460-61, 106 S.Ct. at 2018-19 (quoting Areeda & Turner, *Antitrust Law*, ¶ 1511 (1986)); *see also Bhan v. NME Hosp., Inc.*, 929 F.2d 1404, 1413 n. 10 (9th Cir. 1991); *Reazin v. Blue Cross & Blue Shield*, 899 F.2d 951, 968 n. 24 (10th Cir.), *cert. denied*, ___ U.S. ___, 110 S.Ct. 3241, 111 L.Ed.2d 752 (1990). What plaintiffs fail to realize, however, is that the "proof of actual detrimental effects" requires more than the simple allegation that the closure of TMD and the cessation of Dr. Tarabishi's practice reduced competition. As we have explained previously, what plaintiffs have never shown is that consumer choices were in fact reduced or impaired by the denial of staff privileges to Dr. Tarabishi. *See* n. 14, *supra*.

[16] Indeed, as defendants point out, what evidence there was on this point suggests the opposite conclusion. At the

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that plaintiffs' monopolization claim against the Clinic must fail.

Plaintiffs also charged the Clinic with attempted monopolization. The elements of that section two violation are:

> (1) relevant market (including geographic market and relevant product market) in which the alleged attempt occurred; (2) dangerous probability of success in monopolizing the relevant market; (3) specific intent to monopolize; and (4) conduct in furtherance of such an attempt.

Colorado Interstate Gas Co. v. Natural Gas Pipeline Co., 885 F.2d 683, 693 (10th Cir.1989), *cert. denied*, ___ U.S. ___, 111 S.Ct. 441, 112 L.Ed.2d 424 (1990); *Shoppin' Bag of Pueblo*, 783 F.2d at 161. Further "to satisfy the dangerous probability of success element of an attempt claim, the plaintiff must show that there was a dangerous probability the defendant would achieve monopoly status as the result of the predatory conduct alleged by the plaintiff." *Colorado Interstate Gas Co.*, 885 F.2d at 693. This is typically done by examining the defendant's market share in the relevant market. *Id.*

The district court, relying on its previous conclusion that plaintiffs failed to prove adequately the relevant

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same time Dr. Tarabishi left the Clinic, another doctor also left and set up an independent practice as an internist/cardiologist in competition with the Clinic. His independent practice was very successful.

markets, held that the first two factors were not established. We agree.

We further agree with the district court's alternative conclusion that the third factor – a specific intent to monopolize – was not established. While the evidence in this case may certainly have shown animosity towards Dr. Tarabishi, we must affirm the district court's conclusion that it failed to show a specific intent to monopolize.

In so holding, we reject plaintiffs' argument that defendants' legitimate and protected conduct[17] in opposing Dr. Tarabishi in the Certificate of Need application proceedings furnishes the requisite specific intent to monopolize.

3. *Conspiracy to Monopolize.*

Plaintiffs charged all defendants with various conspiracies to monopolize, in violation of section two. More specifically, plaintiffs argue there were three conspiracies: one between the Hospital and the Clinic; one between the Hospital and the physicians; and one between the individual physicians. The elements of such a claim are:

> (1) . . . a combination or conspiracy to monopolize; (2) . . . overt acts done in furtherance of the combination or conspiracy; (3) . . . a specific

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[17] Plaintiffs do not seriously dispute that defendants' activities in the Certificate of Need application hearings were protected under the *Noerr/Pennington* doctrine. *See United Mine Workers v. Pennington*, 381 U.S. 657, 85 S.Ct. 1585, 14 L.Ed.2d 626 (1965); *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 81 S.Ct. 523, 5 L.Ed.2d 464 (1961).

> intent to monopolize; and (4) . . . an appreciable effect upon commerce.

Dreiling v. Peugeot Motors of Am., Inc., 850 F.2d 1373, 1382 (10th Cir.1988); *see also Bacchus Indus., Inc. v. Arvin Indus.*, 939 F.2d 887, 895 (10th Cir.1991). The district court held for defendants on this claim, noting again plaintiffs' failure to prove a specific intent to monopolize as well as their failure to establish a conspiracy. We affirm with respect to the lack of evidence of specific intent. The issue of conspiracy in this case is, as the district court acknowledged, more difficult. Because it is crucial to plaintiffs' section one claim, we discuss it in that context.

4. *Conspiracy in Restraint of Trade.*

Plaintiffs allege that defendants engaged in a conspiracy to boycott plaintiffs and in a conspiracy to stabilize prices, all, obviously, in restraint of trade. They claim that each of these conspiracies is a *per se* violation of section one. Alternatively, they charge that they violate section one under the rule of reason.

While noting that a group boycott has been held to be a *per se* violation of section one, the district court declined to apply the *per se* analysis to the claimed boycott in this case.[18] We agree with that determination.

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[18] In doing so, the court relied on *Weiss v. York Hosp.*, 745 F.2d 786 (3d Cir.1984), *cert. denied*, 470 U.S. 1060, 105 S.Ct. 1777, 84 L.Ed.2d 836 (1985), in which the court applied the *per se* rule to a contention that a hospital's refusal to grant staff privileges to osteopathic physicians constituted a boycott or concerted refusal to deal. The *Weiss* court noted, however, that:

(Continued on following page)

> A plaintiff seeking application of the *per se* rule must present a threshold case that the challenged activity falls into a category likely to have predominantly anti-competitive effects. The mere allegation of a concerted refusal to deal does not suffice because not all concerted refusals to deal are predominantly anticompetitive.

Northwest Wholesale Stationers, Inc. v. Pacific Stationary Printing Co., 472 U.S. 284, 298, 105 S.Ct. 2613, 2621, 86 L.Ed.2d 202 (1985); *see also Bhan v. NME Hosps., Inc.*, 929 F.2d 1404, 1412 (9th Cir.1991) ("the per se rule should be invoked for a group boycott when the challenged activity would almost always tend to be predominantly anticompetitive"). Denying staff privileges to a physician through peer review on the basis that the physician's conduct is unprofessional and inappropriate is not an activity

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(Continued from previous page)

> The Medical Staff is, however, entitled to exclude individual doctors, including osteopaths, on the basis of their lack of professional competence or unprofessional conduct. If York's policy toward D.O.'s could be viewed as a form of industry self-regulation of this type, the rule of reason, rather than a *per se* rule, would be applicable.

Id. at 820 (citations omitted); *see also Miller v. Indiana Hosp.*, 843 F.2d 139, 144 n. 6 (3d Cir.) ("in a hospital staff privilege case in which the hospital defends on lack of professional ability, the rule of reasons test would apply"), *cert. denied*, 488 U.S. 870, 109 S.Ct. 178, 102 L.Ed.2d 147 (1988). Because defendants in this case terminated Dr. Tarabishi's staff privileges at least obstensibly because of a lack of professional competence or unprofessional conduct, we agree with the district court that *Weiss* does not dictate the use of *per se* analysis.

"likely to have predominantly anticompetitive effects" such that *per se* treatment is necessary.[19]

The district court went on to apply the rule of reason analysis. In doing so, the court correctly noted that the first question is whether plaintiffs proved there was joint action sufficient to satisfy the requirement that there be a contract, combination or conspiracy. *See McKenzie v. Mercy Hosp. of Independence,* 854 F.2d 365, 367 (10th Cir.1988). In this case, the court specifically found that there was "no evidence, apart from the peer review process, that a conspiracy existed." District Court Findings of Fact and Conclusions of Law at 33. After noting that existing precedents do not completely answer the question of whether peer review by itself provides the requisite joint action or whether a hospital can conspire with its medical staff, the court held that, even assuming *arguendo* that joint action was established, plaintiffs once again simply failed to establish the required impact upon *competition.* Plaintiffs' failure to prove adequately the relevant markets within the which competition was allegedly affected, and their failure to prove that Dr. Tarabishi's inability to sue the facilities at the Hospital affected competition, as opposed to Dr. Tarabishi himself as a competitor, doomed plaintiffs' section one claims to

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[19] The district court similarly rejected *per se* treatment of plaintiffs' conspiracy to stabilize prices claim. We affirm, and we further affirm the district court's conclusion that there was "no evidence of such a price stabilization conspiracy, whether directly or through the effect of the peer review proceedings." District Court Findings of Fact and Conclusions of Law at 40.

failure.[20] We affirm. While plaintiffs might wish us to assume or infer an impact on competition based on the denial of Dr. Tarabishi's staff privileges, and the failure of his TMD center the reality is that it is plaintiffs' burden to *prove* such an impact, and plaintiffs simply failed to do so herein.

CONCLUSION

For the foregoing reasons, the judgment of the district court dismissing plaintiffs' claims is AFFIRMED.

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[20] The district court noted that "the only impact upon *competition*, as distinguished from plaintiffs, is based upon the speculation that TMD would ultimately become a hospital. The Court finds this speculation to be tenuous." District Court Findings of Fact and Conclusions of Law at 39. While it is true that there was an area – the provision of out-patient surgery – in which the Hospital arguably did compete with TMD, plaintiffs never quantified the impact on competition in that market.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF OKLAHOMA

M. HISHAM TARABISHI, M.D., and M. HISHAM TARABISHI, INC.,	)	
Plaintiffs,	)	No. 87-652-C
vs.	)	
McALESTER REGIONAL HOSPITAL, a/k/a McALESTER REGIONAL HEALTH CENTER AUTHORITY PUBLIC TRUST STATUS; McALESTER CLINIC, INC.; LEROY M. MILTON, M.D.; GEORGE BROWN, M.D.; WILLIAM G. BLANCHARD, M.D.; SAMUEL E. DAKIL, M.D.; JOHN B. COTTON, M.D.; STEVEN ATWOOD, M.D.; CHARLES K. HOLLAND, M.D.; KARL SAUER, M.D.; HERTZL V. SCHAFF, M.D.; JOE McCAULEY, M.D.; and DON SCHULLER, M.D.,	)	
Defendants.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The above-styled action was brought for alleged violations of federal and state antitrust laws. This case was tried to the Court, and evidence was presented from October 17, 1988 through December 16, 1988. Closing arguments were held on January 20, 1989.

After considering the pleadings, the testimony and exhibits admitted at trial, all of the briefs and arguments presented by counsel for the parties, and being fully advised in the premises, the Court enters the following Findings of Fact, Conclusions of Law and Judgment in accordance with Rule 52, F.R.Cv.P., as follows:

FINDINGS OF FACT

Jurisdiction and Venue

1. This Court has jurisdiction over the subject matter of this case pursuant to 15 U.S.C. § 15 and § 26.

2. Each of the defendants resides and transacts, or has transacted, business within this District. Venue is appropriate under 28 U.S.C. § 1391(b).

3. The Court finds that the activities of plaintiffs and of defendants giving rise to this litigation, as more fully set forth below, are or were in or affecting interstate commerce sufficiently to confer jurisdiction on this Court under 15 U.S.C. § 15. Specifically, plaintiffs have established that moneys for the services that plaintiffs and defendants have provided have flowed in interstate commerce; and that goods and supplies actually purchased by plaintiffs and defendants and that would have been purchased by plaintiffs had they remained in business in McAlester, Oklahoma, travelled in interstate commerce.

4. This Court has jurisdiction over plaintiffs' state law claims under the doctrine of pendent jurisdiction.

The Parties

5. Plaintiff M. Hisham Tarabishi, M.D. (Tarabishi) is a medical doctor, and a naturalized American citizen. Tarabishi is an otorhinolaryngologist, more commonly known as an "Ear, Nose and Throat" (ENT) specialist. In or about the fall of 1979, Tarabishi obtained "Board Certification" in his specialty.

6. Plaintiff M. Hisham Tarabishi, Inc., also known as "TMD Out-Patient Medical Center" and "Tarabishi Medical Center" (TMD) is the professional corporation through which Tarabishi has conducted business as a physician, and through which he sought to operate TMD, an outpatient surgical clinic in McAlester, Oklahoma.

7. Defendant, McAlester Regional Hospital, a/k/a McAlester Regional Center Public Trust Status (the Hospital or MRH) is a 200 bed Oklahoma public trust hospital located in McAlester, Oklahoma, and created under 60 O.S. § 176-180 by the City of McAlester. The Hospital in its current facility was created in 1978 after the consolidation of two pre-existing hospitals in McAlester (Pittsburg County, Okla.) into one modern hospital. The City owns the lands upon which the Hospital sits and merely leases them to the Hospital's governing body.

8. The Hospital was originally constructed with funds from various sources, including $1.5 million from issuance of general obligation bonds by the City of McAlester, and other funds from public and private sources. The Hospital exists as a Public Trust under Oklahoma law, whose beneficiary is the City of McAlester.

9. McAlester Clinic, Inc. (the Clinic) is an Oklahoma professional corporation now comprised of approximately 20 physicians as well as other employees. During the events here primarily at issue, in 1983 and 1984, the Clinic employed approximately 17 or 18 physicians, most of whom were "partners" or equity owners in the professional corporation. The Clinic physicians represent a spectrum of medical specialties, including general or family practice, internal medicine, general surgery, pediatrics, radiology, and ENT.

10. Defendants Leroy M. Milton, M.D. (Milton) (internal medicine); George Brown, M.D. (Brown) (general surgery); William G. Blanchard, M.D. (Blanchard) (general surgery); Samuel E. Dakil, M.D. (Dakil) (ent); John B. Cotton, M.D. (Cotton) (family practice); Steven Atwood, M.D. (Atwood) (internal medicince/emergency medicine); and Charles K. Holland, M.D. (Holland) (internal medicine) are or were at the relevant times members of the Clinic with the indicated areas of specialty practice. Milton was at all relevant times a member of the MRH Board of Trustees, as was Holland at least in the period 1982-1984. In or about May, 1984, Milton became the "Chief of Staff" at the Hospital, which is the chief administrative office for physicians having privileges at the Hospital. The Chief of Staff is elected by other members of the Hospital medical staff to a one year term that runs approximately from May of one year through April of the following year. The Chief of Staff is responsible for appointing members of various "*ad hoc*" and standing committees of the Hospital medical staff, and is invested with a variety of administrative duties.

11. Defendants Karl Sauer, M.D. (Sauer) (orthopedic surgery); Hertzl V. Schaff, M.D. (Schaff) (general surgery); Joe McCauley, M.D. (McCauley) (family practice); and Don Schuller, M.D. (Schuller) (radiology) are physicians who have also had medical staff privileges at MRH at all relevant times, but are not members of or affiliated with the Clinic. Sauer, Schaff, and McCauley practice individually, and Schuller is a member of a small group unaffiliated with the Clinic.

12. Plaintiffs have named as co-conspirators but not as defendants several other physicians who have also practiced at MRH. These include Michael Boyer, M.D. (Boyer) (anesthesiology); James Dunagin, M.D. (Dunagin) (ophthalmologic surgery): Merlyn Bellamy, M.D. (Bellamy) (pathology); and Thurman Schuller, M.D. (T. Schuller) (pediatrics). Dunagin has not had any affiliation with the Clinic. Dunagin served as Chief of Staff at MRH from May, 1983 to April, 1984. Bellamy has had no affiliation with the Clinic. T. Schuller has been a member of the Clinic, and at least in the late 1970's and early 1980's he served as the internal "chief of staff" at the Clinic.

The Early Years

13. Dr. Tarabishi received his initial medical education at Alexandria University in Alexandria, Egypt where he graduated in 1966 as a Doctor of Medicine. From 1966 to 1969 Dr. Tarabishi completed a one year internship and a two year residency in ENT at the University Hospital at the University of Alexadria and became board certified in ENT in Egypt in 1969.

14. Dr. Tarabishi came to the United States in February, 1970. He worked at part time non-physician medical jobs while studying for the Equivalency Exam for Foreign Medical Graduates (ECFMG) which he passed in December 1970. Also during this time, Dr. Tarabishi's wife, Farida, herself an Egyptian born, educated and trained doctor, came to the United States and set out to become United States qualified.

15. After both had passed the ECFMG, Dr. Tarabishi and his wife moved to Pittsburgh, Pennsylvania where each of them commenced medical internship training. Dr. Tarabishi performed a general rotating internship at St. Margaret Memorial Hospital from July 1971 until June 1972. Thereupon, he commenced his residency training and completed a 12 month general surgery residency at St. Margaret Memorial Hospital from July 1972 until June 1973. Thereafter, from July 1973 until June 1974, Dr. Tarabishi completed an additional one year of residency in ENT at the Eye and Ear Hospital at the University of Pittsburgh. A conflict developed in the fall of 1973 between Dr. Tarabishi and his "supervisor" Dr. Myers, allegedly because Dr. Myers did not want Arab doctors in the program in the wake of the 1973 Arab-Israeli war. In any event, litigation by Tarabishi against Dr. Myers and the Hospital ensued, resulting in a settlement.

16. In 1975, Dr. Tarabishi became a United States citizen. The same year, Tarabishi transferred to the ENT residency program at the University of Utah and completed his training in or about 1977. He turned to advertisements in progressional journals to seek job opportunities, and accepted a position as an ENT surgeon with the Marshfield Clinic in Marshfield, Wisconsin thus

availing himself of an established patient base with which to establish his practice. He remained in the employ of the Marshfield Clinic from July 1977 to May 1979, and thereafter sought to relocate to a warmer climate and a less isolated location. After again referring to professional periodicals, Tarabishi contacted the Clinic, in McAlester, Oklahoma. The Clinic had been seeking a second ENT to join its existing ENT specialist, Dr. Sam Dakil, for some time.

17. Following preliminary discussions and meetings, Tarabishi was offered and accepted employment with the Clinic pursuant to a written contract. He started to work at the Clinic in May, 1979. Contemporaneously with commencing his employment at the Clinic, Dr. Tarabishi was granted full staff privileges at the defendant Hospital. By November or December, 1979, differences had developed between Dr. Tarabishi and the Clinic over provisions relating to employment, compensation and pension vesting. Upon learning that Dr. Tarabishi was looking at other office space, the Clinic decided upon and announced his termination from employment.

18. At a Clinic special staff meeting, on December 7, 1979, attended by defendant Doctors Holland, Milton, Dakil, Cotton, Brown and Blanchard, the minutes reflect:

> Doctor Thurman Schuller, Chief-of-Staff, stated that he felt it was important for the Staff to adopt a position on the doctors leaving the Clinic, to wit: Doctors Abdolkarim Khorasanchian and M. Hisham Tarabishi. Doctor Schuller requested that the Staff adopt a position that it was impossible for the McAlester Clinic to do business with Doctors Tarabishi and

Khorasanchian since the philosophies of the Clinic and these two doctors were incompatible.

(Plaintiff's Exhibit[1] 101).

19. Dr. Tarabishi's employment at the Clinic ceased in January, 1980. After leaving the Clinic, Dr. Tarabishi opened his own medical practice, such practice consisting of some general surgery, an office medical practice and otolaryngological surgery. In 1982, Dr. Tarabishi was elected President of the Medical Society of Pittsburg County, Oklahoma.

Dr. Tarabishi's Outpatient Surgical Facility

20. During an interview of Dr. Tarabishi by a reporter for the local McAlester newspaper in February, 1982, Tarabishi spoke out against the high cost of medical services, the hardship such high costs create, and the damage done to the economy. In this and other similar public statements, Dr. Tarabishi placed part of the blame on the medical profession itself, and the failure of the medical profession to utilize innovative cost savings techniques which could lead to a substantial reduction in the cost of medical care. (p.ex.1).

21. In 1982, Dr. Tarabishi formulated a plan to establish the TMD Center, to be located in McAlester. In connection with such plans, Dr. Tarabishi caused an evaluation to be made of the economic feasibility of the establishment of such a medical center. An initial feasibility study was conducted by two certified public

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[1] *hereafter "p.ex."*

accountants retained for this purpose by Dr. Tarabishi. Subsequently, additional feasibility studies were conducted in connection with an application for financing for the TMD Center. Based upon the analyses by these accountants, it was determined that Dr. Tarabishi's planned center would be economically practicable and feasible.

22. Under the laws of the State of Oklahoma, it is necessary to obtain approval of various State agencies which, during the time period in question, regulated the establishment and/or expansion of some medical facilities within this State. The procedure by which this was done was called a licensing and "Certificate of Need" procedure. The agency passing on applications for Certificates of Need, and the granting of the licenses to such facilities in Oklahoma was the Oklahoma Health Planning Commission.

23. In late 1982, Dr. Tarabishi hired a respected health care industry consultant, Mr. Jerry Colclazier, to assist in preparation of his Certificate of Need Application. In the course of evaluating such undertaking, and subsequently carrying it out, Mr. Colclazier conducted an independent investigation of the need for, and desirability of, Dr. Tarabishi's outpatient ambulatory surgical center; and further conducted an inquiry concerning Dr. Tarabishi himself, including interviews with various persons associated with defendant MRH. Based upon these inquiries, Mr. Colclazier concluded that an outpatient ambulatory surgical center of the sort envisioned by Dr. Tarabishi was needed in McAlester, and that Dr. Tarabishi possessed the capability of establishing and operating such a facility. Accordingly, Mr. Colclazier decided to

represent Dr. Tarabishi in the Certificate of Need proceedings before the Oklahoma Health Planning Commission, and began to prepare the written Certificate of Need Application. Such Application was finalized and filed on March 14, 1983. (p.ex.24).

24. Consistent with the advice of Mr. Colclazier, Dr. Tarabishi attempted to get a commitment from MRH to maintain a "position of neutrality" in relation to his Certificate of Need Application. Upon receiving Dr. Tarabishi's request, the MRH Board appointed a three (3) man ad hoc committee to investigate. The ad hoc committee was comprised of the defendant Dr. C. K. Holland, Chuck McBee and John Alexander (Dr. Tarabishi's former accountant.) The committee met with Dr. Tarabishi and questioned him regarding his plans for TMD. Specific inquiry was made regarding Dr. Tarabishi's financial plans and projections. The ad hoc committee also inquired about the nature and type of medical procedures and practice planned by Dr. Tarabishi for the TMD Center.

25. Thereafter, in or about October 1982, MRH informed Dr. Tarabishi that its position regarding the proposed TMD was that it had no interest in the medical practice of a physician conducted in his own office. However, MRH would not comply with Dr. Tarabishi's request for a "position of neutrality" for use in the Certificate of Need Application process.

26. In January 1983, Dr. Tarabishi wrote a letter to the MRH Board, specifically addressed to Chairman John Alexander, once again requesting that MRH formally

state a "position of neutrality" with regard to the proposed TMD Center and to his to-be-filed Application for Certificate of Need. To this renewed request the MRH Board stated that its position was "the same as it was in October 1982, at which time a letter was sent to Dr. Tarabishi stating that surgical procedures conducted within the confines of individual physician offices are outside the authority's purview" (p.ex.81 – January 5, 1983 minutes).

27. As reflected by the minutes of its board of directors, in February 1983, MRH, through its board, discussed for the first time, creation of its own outpatient ambulatory surgery service. (p.ex.81 – February 2, 1983 minute, page 2). MRH board minutes in March, 1983, reflect that "renovations are underway" for completion of an outpatient ambulatory surgery department. The "new" department was to be ready for business by April 1, 1983.

28. In May 1983, as reflected by the minutes of the MRH board, Administrator Ed Majors "announced" to the board that "unless the Board directs otherwise" MRH would respond to the Oklahoma Health Planning Commission that the TMD Center "will duplicate the hospital's surgical services." The minutes reflect that to Mr. Majors' announcement "[t]here were no other comments." (p.ex.81 – May 4, 1983 minutes, page 1).

29. Dr. Tarabishi was not informed of MRH's change in position toward the TMD Center until the morning of the first hearing on his application in Oklahoma City when five individuals from the McAlester medical community appeared in opposition. In fact, before the first hearing one Gary Brock, MRH Assistant

Administrator, expressly stated to Dr. Tarabishi that MRH would not oppose the Certificate of Need Application.

30. Prior to the hearings before the Oklahoma Health Planning Commissions, there were no further discussions by the Hospital board relating to opposing, or not opposing, Dr. Tarabishi's Certificate of Need Application. However, Ed Majors, Administrator of MRH, Gary Brock, then Assistant Administrator, Tom Giandrone, Comptroller, and Dr. Leroy I. Milton, then a shareholder of the defendant Clinic and Member of the Board of Trustees of MRH, appeared in Oklahoma City and opposed Dr. Tarabishi's Application.

31. The hearings before the Oklahoma Health Planning Commission in Oklahoma City on Dr. Tarabishi's Application for Certificate of Need were held on May 12, 19, and 25, 1983.

32. On April 29, 1983, Dr. Tarabishi received from MRH, a letter signed by the defendant J. W. McCauley, which notified such plaintiff that the Executive Committee of the medical staff of MRH had been reviewing his medical records for illegibility. The letter warned that "a sampling of your records will be reviewed in one month. If the records are still not legible, then the Executive Committee will take further steps at that time regarding suspension of medical staff privileges for incomplete records." (p.ex.38).

33. On May 3, 1983, Dr. Tarabishi received from MRH, signed by the defendant Don H. Schuller, a letter notifying him that the Executive Committee of the medical staff of MRH had reviewed his attendance at MRH Library Committee meetings. The letter stated that Dr.

Tarabishi's failure to meet certain attendance requirements "shall be grounds for corrective action leading to revocation of medical staff membership . . . " (p.ex.40).

34. On May 17, 1938, an MRH "standing committee", the Pharmacy & Therapeutic's Committee, chaired by Dr. LeRoy M. Milton, (an attendee at the May 12, 1983 TMD Certificate of Need hearing) recommended that Dr. Tarabishi's clinical privileges at MRH be reduced, based upon an allegation that Dr. Tarabishi had been involved in a "potentially life-threatening therapeutic error." The alleged therapeutic error had occurred four (4) months earlier (p.ex.56(g)).

35. On June 6, 1983, after the granting of the TMD Certificate of Need, Dr. Tarabishi was notified that MRH intended to commence "corrective action" proceedings to investigate the "Darby" case, involving the dosage of lidocaine, the "alleged therapeutic error." (p.ex.56(i)).

36. At each hearing before the Oklahoma Health Planning Agencies held on Dr. Tarabishi's Certificate of Need Application the aforesaid representatives from the McAlester area medical community appeared and vigorously opposed the application. In opposing the establishment of the TMD Center, hospital administrator Ed Majors claimed that it would hurt MRH financially, by costing the Hospital substantial sums, including approximately $387,500 during the first year, $432,800 the second year and $472,000 the third year of TMD's operations. (p.ex.25(a) at page 5).

37. Dr. Tarabishi specifically stated to the Oklahoma Health Systems Agency during the application hearing

that he had plans for five additional physicians to utilize the proposed facility. (p.ex.25(b), page 10).

38. Mr. Majors of MRH stated to the Oklahoma Health Systems Agency that if five physicians practice at the proposed outpatient facility "the problems (financial impact) will be five times greater." (p.ex.25(b) page 10).

39. At the hearings before the Oklahoma Health Systems Agency Mr. Majors stated that "if the trend to pull services from hospitals continues, the hospitals will be financially doomed and costs will soar." (p.ex.25(b) at page 10).

40. MRH believed, and its administrator, Ed Majors, testified that the TMD Center would take away the paying, "cream of the crop", patients and leave MRH with the "low pay, no pay patients".

41. While opposing the Certificate of Need Application on the ground that an outpatient ambulatory surgical facility was not needed in McAlester, MRH itself established and opened its out-patient ambulatory surgical facility in April, 1983.

42. Also, at or near the time that it became known to defendants that Dr. Tarabishi was moving forward with his plans, MRH initiated new promotion and public relations endeavors. These included developing advertising which was run in the McAlester newspapers and the preparation of a new "slide show", highlighting the new outpatient ambulatory surgical center. (p.ex.81).

43. Beginning in July, 1981 and continuing until April, 1982, Dr. Tarabishi purchased real property located

in downtown McAlester to be the site for the TMD Center. The property consisted of three lots, two of which contained buildings which Dr. Tarabishi had hoped to be able to remodel and use as part of the TMD Center. However, the existing structures were not feasible renovation projects, for engineering reasons, and the buildings had to be demolished. Two of the lots were purchased by Dr. Tarabishi with cash he had on hand. After site preparation and demolition, Dr. Tarabishi had spent approximately $160,000 on these two lots. The additional third lot was purchased for $200,000 with borrowed funds after financing for the TMD project was finally in place.

44. Dr. Tarabishi first applied to the First National Bank of McAlester for a loan in the amount of $1,000,000 to finance construction of the TMD Center. At the time of the filing of such application, the President of the First National Bank was one Clark Bass. Mr. Bass had been instrumental in the establishment of MRH and had for years served on its Board of Trustees. There was inconsistent testimony as to whether any commitment from this bank was ever made.

45. In the spring of 1983, Dr. Tarabishi applied to another McAlester bank, the American Bank of Commerce. With the assistance of a guarantee by the United States Small Business Administration, a commitment was obtained from such Bank for a loan in the amount of $1,000,000 which was subsequently revised upward to $1,250,000 as construction on the TMD Center progressed. The Bank required and obtained a real estate mortgage on all three of Dr. Tarabishi's lots, including those two (2)

lots that Dr. Tarabishi owned and which were previously unencumbered.

46. Construction of the building for TMD Center began in July, 1983; and the construction was completed one year later. The total cost of construction, including the cost of real estate and site preparation, was approximately $1,050,000.

47. In addition to the cost of construction of the facility, there were costs of equipping and furnishing the same. Total costs of equipping and furnishing the facility were approximately $200,000. Dr. Tarabishi paid these monies from his own funds.

48. The TMD Center opened and began operations on July 9, 1984. TMD was operated by M. Hisham Tarabishi, Inc. The facility itself was owned by Dr. Tarabishi, individually, and was leased to the professional corporation. It continued in operation until August 31, 1985, at which time it ceased operations and plaintiff's medical practice in McAlester was terminated.

Plaintiff has attempted to restore his medical practice in Pennsylvania, but has been unable to obtain hospital privileges. The revocation by MRH has directly contributed to this failure.

49. The TMD Center was not equipped to deal with medical/surgical matters of a complex nature. Access to the facilities of MRH was needed in the event that complications developed during procedures at the TMD Center. TMD did not have the facilities, equipment or staff for emergency situations so that Dr. Tarabishi required access to the MRH emergency room also.

50. Dr. Tarabishi's surgical and emergency room hospital privileges were summarily revoked effective May 24, 1984. Thereafter, he could no longer respond to medical emergencies at MRH for his patients and could no longer perform surgery at MRH.

51. On July 17, 1984, MRH revoked all staff privileges of Dr. Tarabishi so that he could no longer use its facilities for any purposes. On at least one occasion, Dr. Tarabishi's patient was told that Dr. Tarabishi could not even appear at MRH to confer with or console a patient, even as a friend.

52. As a condition for licensing the TMD Center, the Oklahoma Health Planning Commission required that TMD have access to the MRH emergency care hospital facilities. This condition could be met as long as the physician operator of the facility had full medical staff privileges at the emergency care hospital.

53. Upon revocation of Dr. Tarabishi's MRH staff privileges, and thereafter, the TMD Center failed to meet the Oklahoma Health Planning Commission requirement set forth above.

54. In November, 1984, MRH entered into what was termed a "transfer agreement" with Dr. Tarabishi and his facility. The effect of such "transfer agreement" was to allow patients from plaintiffs' facility to be admitted to MRH in the event of an emergency so requiring. However, the "transfer agreement" did not permit Dr. Tarabishi to continue to treat patients after such admission.

55. Dr. Tarabishi informed each of his patients considering surgery at TMD about the limitations on his

treatment and care in the event of surgical emergencies requiring transfer to MRH.

56. Pursuant to the by-laws of MRH, its staff comprised and served on certain "standing committees" including, among others, the Executive Committee, Pharmacy and Therapeutic Committee, Medical Committee, Emergency Room Committee, ICU Committee, Surgical Committee, By-laws Committee and Library Committee.

57. Several of the "standing committees" at MRH were influential and powerful in regard to establishing medical staff policy, patient and medical procedure review, staffing and personnel matters, and physician peer review. These standing committees could direct the medical chief-of-staff to initiate investigations against a physician staff member for purposes of discipline, reduction of staff privileges, or removal from the MRH staff. The Pharmacy & Therapeutic Committee in November 1983, made disciplinary recommendations regarding Dr. Tarabishi to the MRH chief-of-staff.

58. On May 1, of each year, new appointments were made to the medical staff "standing committees", chiefs of service, and chief-of-staff.

59. Following Tarabishi's announcement of his intentions to establish an outpatient surgical facility, the clinic physicians increased their percentage and dominations of key MRH "standing committees". (p.ex.78 & 88).

60. The Clinic physicians held key positions of authority on all important MRH "standing committees". By May of 1984, and for many periods of time preceding

that, the physician chief of each medical service within MRH was from the Clinic.

61. After May 25, 1983, the date upon which the Oklahoma Health Planning Commission granted the Certificates of Need for TMD, Dr. Tarabishi was made the subject of several MRH "corrective action" charges which led to "disciplinary investigations". Prior to that date Dr. Tarabishi had never been subjected to disciplinary charges.

62. From June 1983 until July 17, 1984, Dr. Tarabishi was charged and investigated by various ad hoc, hearing review and appellate committees or boards at MRH. The incidents and subsequent proceedings will now be described.

The Darby Incident

63. The "Darby" Incident occurred on January 30, 1983. (The Incident Report is Defendants' Exhibit[2] 68-40). It involved an alleged overdose of lidocaine. On April 27, 1983, the Pharmacy and Therapeutics Committee met and resolved to ask for Dr. Tarabishi's response to the incident. (d.ex.68-41). A memo was sent to Tarabishi. (d.ex.68-42). On May 17, 1983, the P and T Committee referred the matter to the executive Committee with the recommendation that Tarabishi's clinical privileges be reduced, and specifically that Tarabishi not be permitted to administer any cardiac drugs. (d.ex.68-43). The Executive Committee appointed an ad hoc committee. On June

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[2] *hereafter "d.ex."*

13, 1983, the ad hoc committee informed Tarabishi that the dosage given was excessive. (d.ex.68-44). No further action was taken. On July 21, 1983, the Emergency Room Committee recommended no further action be taken. (d.ex.68-45). The Executive Committee accepted this recommendation on July 22, 1983. (d.ex.68-54).

A "second investigation" into the Darby matter was announced on January 14, 1984, along with other matters. (p.ex.60d). On January 18, 1984, an ad hoc committee held a hearing. (p.ex.60f). The committee requested a written response (p.ex.60e), but did not receive one (p.ex.60g). The committee issued its report, adverse to Tarabishi. (p.ex.60h). The Executive Committee made a decision favoring revocation. (p.ex.60y). A Review Committee met on April 7 and 26, 1984. (p.ex.65 & 67). On May 3, 1984, that committee issued its report. (p.ex.60o). The Executive Committee affirmed the Review Committee. (p.ex.61(p)). The governing body made its decision of revocation. (p.ex.68 & 69). On July 18, 1984, Dr. Tarabishi's privileges were revoked. (p.ex.70).

The Ketcherside Incident

64. The Ketcherside incident began on September 15, 1983, when Dr. Tarabishi, a member of the Surgery Committee, made a recommendation to the attention of the Executive Committee that an ad hoc committee be formed. (d.ex.68-57). The Surgical Committee acknowledged his request (d.ex.68-58), and reviewed the case (d.ex.68-59). On November 11, 1983, the Surgical Committee voted unanimously to remove Tarabishi from the committee or suspend him until he "prove[d] himself

innocent" of charges of breach of confidentiality. (d.ex.68-62) (d.ex.68-64). A letter of suspension was sent (d.ex.68-65). On December 6, 1983, the ad hoc committee found Tarabishi guilty of unethical and disruptive behavior, and stated it would report same to the Executive Committee (d.ex.68-68). On January 4, 1984, the Executive Committee placed Tarabishi on one-year probationary status. (d.ex.68-72). Tarabishi appealed. An ad hoc hearing voted 2-1 in Tarabishi's favor. (d.ex.68-79). On March 12, 1984, the Executive Committee reprimanded Tarabishi. (d.ex.68-83). Tarabishi again appealed (d.ex.68-84), and on May 2, 1984, the decision was affirmed. (d.ex.68-89).

The Jacobs Incident

65. The Jason Jacobs incident concerns an eight-year-old asthmatic hospitalized for a tonsillectomy. His surgery was scheduled for May 21, 1984.

After the incident, Tarabishi was sent a letter from Dr. George Brown summarily suspending Tarabishi's Emergency Room/Operating Room privileges. (p.ex.71(p)). An ad hoc committee was formed, which issued its report on June 21, 1984, holding that the summary suspension should remain in effect until final disposition by the governing board. (p.ex.71(cc)). The Executive Committee approved the ad hoc committee report on June 22, 1984. (p.ex.71(ee)).

The Parks and Weaver Incidents

66. The Stephanie Parks incident involved a written report by Dr. Boyer that Dr. Tarabishi had inadequately evaluated a patient for surgery. (p.ex.61(a)).

The Amber Weaver incident involved a written report by Boyer that Tarabishi had not seen and examined Amber Weaver prior to the time of surgery. (p.ex.61(b)).

The Chief of Staff, Dr. Dunagin, Sent Tarabishi a letter alleging "serious new charges". (p.ex.61(c)). On February 28, 1984, the ad hoc committee met and recommended disciplinary action. (p.ex.61(g)). The Executive Committee concurred in the findings on March 1, 1984. (p.ex.61(i)).

The Price Incident

67. The Gary Price incident occurred on December 18, 1983. (d.ex.68-93). A fourteen-year-old boy received a gunshot wound to the face and Dr. Tarabishi placed him in the Emergency Room. Dr. Boyer wrote the Hospital that he believed that the actions of Dr. Tarabishi were not warranted by the patient's condition. An ad hoc committee was formed. (p.ex.60d). The committee, consisting of Dr. Don Schuller, Dr. Sauer, and Dr. Brown, ultimately concluded that Dr. Tarabishi was guilty of "inappropriate assessment and management of emergency cases." (p.ex.60h). On February 23, 1984, the Executive Committee recommended revocation of Dr. Tarabishi's medical staff privileges, (d.ex.68-144), based upon the Price incident, among others.

The McCabe Incident

68. The Brandon McCabe incident occurred on December 20, 1983. (d.ex.68-92). Dr. Tarabishi wrote his own incident report. (d.ex.68-94). An ad hoc committee was assigned, which investigated both this incident and the Price incident.

The Jackson Incident

69. In a letter to Dr. Dunagin dated December 26, 1983, Dr. Tarabishi wrote that Dr. Boyer "failed to properly evaluate the patient pre-operatively to clear him for a general anesthesia – which cost the patient his life." (d.ex.68-94). In the ad hoc meeting of January 18, 1984, regarding the McCabe and Price cases, Dr. Tarabishi was asked about the statement in his letter and Dr. Tarabishi supplied the patient's name as Mr. Jackson. The committee rendered findings adverse to Dr. Tarabishi. (d.ex.68-127).

Ultimate Revocation

70. On February 3, 1984 an ad hoc committee issued its report. The committee took account of I. the McCabe case, II. the Price case, III. Dr. Tarabishi's accusation against Dr. Boyer of traumatic intubation, IV. the Jackson case, V. the Darby case, and VI. the Ketcherside case. It also discussed the illegibility of Dr. Tarabishi's handwriting. (d.ex.68-127). On February 23, 1984, the executive committee recommended the revocation of Dr. Tarabishi's medical staff privileges.

On May 3, 1984, the Hearing Appeals Committee issued its report on the "seven charges" against Dr. Tarabishi. (d.ex.68-169). On May 8, 1984, the executive committee recommended that Dr. Tarabishi's staff privileges be revoked (d.ex. 68-170). On July 18, 1984, Dr. Tarabishi was notified that his appeal was denied. (d.ex.68-178).

71. To the extent that these Findings of Fact constitute Conclusions of Law, they shall be so considered.

CONCLUSIONS OF LAW

At the Court's request, the plaintiffs submitted a summary of their proposed theories of recovery. The Court will address each theory in turn.

Individual Monopolization by Defendant Hospital

Plaintiffs contend that defendant MRH individually monopolized its market, in violation of 15 U.S.C. § 2. It has been held that

> [t]he elements of monopolization under Section 2 are "the possession of monopoly power in the relevant market" and "the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident."
>
> *Bright v. Moss Ambulance Service, Inc.*, 824 F.2d 819, 823 (10th Cir. 1987).

Monopoly power is defined as the ability to control prices *and* exclude competition. Both elements must be demonstrated to establish the existence of monopoly power. *Id.*

at 824. Before it can be determined whether monopoly power exists, the plaintiff must define the relevant geographic and product market. *Feldman v. Jackson Memorial Hosp.*, 571 F.Supp. 1000, 1010 (S.D.Fla. 1983), *aff'd mem.*, 752 F.2d 647 (11th Cir.), *cert. denied*, 472 U.S. 1029 (1985). Determining the relevant product market necessities an examination of which commodities [in the case at bar, services] are reasonably interchangeable by consumers for the same purposes. *Westman Comm. Co. v. Hobart Int'l, Inc.*, 796 F.2d 1216, 1221 (10th Cir. 1986), *cert. denied*, 108 S.Ct. 1728 (1988). The geographic market is the narrowest market which is wide enough so that products [services] from adjacent areas cannot compete on substantial parity with those included in the market. *Id.* at 1222. One commentator has perhaps more clearly stated that "[t]he relevant geographic market is that area in which patients can realistically obtain the relevant services, the geographic area in which the provider markets the relevant services, or both." Enders, *Federal Antitrust Issues Involved in the Denial of Medical Staff Privileges*, 17 Loy.U.Chi.L.J. 331, 360 (1986). Plaintiffs' expert defined the relevant market for MRH as the business of supplying surgical health care services [product market] within a thirty-mile radius of McAlester, Oklahoma [geographic market]. *See* Transcript of testimony of Joe Jadlow at page 22, LL.6-9 [hereafter Jadlow Tr.]. He further found that, according to bed count, MRH had about 75 percent of market. (Jadlow Tr. at 23, LL.4-5). He stated that he found evidence that MRH had monopoly power. (Jadlow Tr. at 22, L.22). Plaintiffs contend that MRH's monopoly power was demonstrated by (1) its exclusion of plaintiffs from the market, and (2)

its market share of over 75%. (Plaintiffs' Proposed Findings of Fact and Conclusions of Law at ¶ 105).

The Court finds several problems with the market thus defined. First, the geographic radius was derived from an examination of MRH discharge records and a finding that 84% of its discharged patients lived within thirty miles of McAlester. (Jadlow Tr. at 13, LL.17-25). As was pointed out on cross-examination, plaintiffs' expert did not take into account whether patients who lived within the 30-mile radius went elsewhere than MRH for surgical health care services. (Jadlow Tr. at 115, L.18). The "time factor" which might keep patients close to home was not quantified. Further, it appears extremely doubtful that "bed count" is an appropriate measure of market share in the market of "surgical health care services." The mere words of the plaintiffs' market definition denote more than the provision of a hospital bed. Even at this late date, it is not clear whether plaintiffs contend that both of them or only one of them was harmed by the alleged monopoly. The Court will first view Dr. Tarabishi as the aggrieved party. Dr. Tarabishi, as distinguished from TMD, provided *surgery* or *surgical services* to his patients. If words have meaning, these terms describing the product produced by a surgeon, and the term "surgical health care services" involve distinct products. In *White v. Rockingham Radiologists, Ltd.*, 820 F.2d 98 (4th Cri. 1987), the court stated that one who is neither a provider nor a consumer of a service may not prevail on a claim of monopoly with regard to that service. *Id.* at 104. The same conclusion applies to Dr. Tarabishi in the case at bar. In *Feldman, supra*, the plaintiff-podiatrist defined the relevant product market as "surgical services". The district

court rejected this definition. "Since hospitals cannot perform surgery (they sell health care facilities), there could not be a viable monopoly claim in this action against the hospitals. They and [plaintiff] were not competitors, nor could they be." 571 F.Supp. at 1010 n.15.

As for TMD, that facility did not have beds. (Jadlow Tr. at 193 L.2). While some TMD patients might have used beds in MRH, this fact would not transform TMD into a consumer within the market. Therefore, the Court concludes that TMD's claim under this theory also fails. Most fundamentally, the Tenth Circuit requires proof of both ability to exclude competition *and* to control prices. Plaintiffs' expert conceded that he had not examined whether MRH had evidenced monopoly power in its pricing. (Jadlow Tr. at 243 LL.6-11). Therefore, a showing of monopoly power has not been made. For all of these reasons, the Court must conclude that plaintiffs failed to prove their claim of individual monopolization against defendant MRH.

Individual Monopolization by Clinic

Plaintiffs allege individual monopolization on the part of defendant Clinic. The elements of the offense have been previously stated. *See Brights*, 824 F.2d at 823. Plaintiffs' expert defined the relevant market for the Clinic as the business of supplying nonsurgical and office surgery health care services within a thirty-mile radius of McAlester. (Jadlow Tr. at 22, LL.12-15). He stated that the Clinic had a 66% share in that market. (Jadlow Tr. at 138, L.23). He described his determination of market share as follows:

> And I did this by looking to see what were the specialties of the physicians at the McAlester Clinic. I included those specialties in looking at *the total number of physicians in the McAlester community*, and I looked to see what proportion of that total group physicians the McAlester Clinic accounted for.
>
> Jadlow Tr. at 24, LL.8-12 (emphasis added)

See also Jadlow Tr. at 143, LL.11-19. While defining the geographic market as a 30-mile radius, plaintiffs' expert focused only on doctors within McAlester itself. He did not consider doctors within the radius who did not practice in McAlester. (Jadlow Tr. at 144, LL.7-18). A recurring theme in his testimony was that he focused solely upon the Clinic and the City of McAlester. (Jadlow Tr. at 149, LL.9-10; 153, L.25-154, LL.1-6; 156, LL.16-20). Dentists who perform root canal work, for example, while appearing to fall within the language of plaintiffs' product market definition, were excluded solely because plaintiffs' expert did not believe such surgery was done at the Clinic. (Jadlow Tr. at 147, LL.8-9 and LL.22-24). Regarding the proposed geographic market, plaintiffs' expert at one point characterized it as an approximation. (Jadlow Tr. at 158, L.21). However, it is clear that the actual geographic area studied was the City of McAlester itself. In sum, both as to product market and geographic market, the procedure of plaintiffs' expert varied from the actual proposed markets. Relevant markets were not properly defined. Also, no showing was made of the ability of the Clinic to exclude competition and to control prices. The Court concludes that this claim also fails.

Attempted monopolization by defendant clinic

Plaintiffs also contend that the clinic is guilty of an attempted monopolization in violation of 15 U.S.C. § 2. Proof of this offense requires the establishment of four factors:

> 1) a relevant market in which the alleged attempt occurred; 2) a dangerous probability of success in monopolizing the relevant market; 3) a specific intent to monopolize; and 4) conduct in furtherance of such an attempt.
>
> *Lease Lights, Inc. v. Pub.Serv.Co.*, 849 F.2d 1330, 1335 (10th Cir. 1988).

The Court has already described the inadequate market definition in the case. Thus, the Court concludes that plaintiffs failed to establish the first two elements. Even if they were established, however, plaintiffs presented no evidence of specific intent to monopolize on the Clinic's part. The Court is aware that specific intent need not be expressed; it may be inferred from past conduct, from statements, from contemporaneous documents, or even from the potentiality of monopoly power. 3 Von Kalinowksi, *Antitrust Laws and Trade Regulation*, §9.01[4] (1989). While plaintiffs argue that such intent may be found in that one is presumed to intend the probable consequences of his acts, this Court believes that such an argument comports more with a finding of general intent. This is insufficient regarding attempted monopolization. *See Times-Picayune Publ. Co. v. United States*, 345 U.S. 594, 626 (1953).

Conspiracy to Monopolize

The plaintiffs urge against all defendants a conspiracy to monopolize in violation of 15 U.S.C. §2. To succeed on such a claim,

> (1) The plaintiff must demonstrate a combination or conspiracy to monopolize; (2) there must be overt acts done in furtherance of the combination or conspiracy; (3) the defendants must have a specific intent to monopolize; and (4) the combination or conspiracy must have an appreciable effect upon commerce.
>
> *Drilling v. Peugeot Motors of America, Inc.*, 850 F.2d 1373, 1382 (10th Cir. 1988).

The Court discusses the issue of conspiracy *infra*. However, even if a finding of conspiracy could be made in this case, again there was no evidence of specific intent to monopolize. The Court rules for the defendants on this claim.

Violation of the Essential Facilities Doctrine

Plaintiff alleges that defendant MRH violated the essential facilities doctrine through its revocation of Dr. Tarabishi's privileges. Plaintiffs' argument is that since Dr. Tarabishi was competing with a portion of the facilities and services of MRH through the TMD Surgery Center and needed access to the other, more complex, facilities of such defendant in order to continue the operation of the TMD Center, the Hospital acted to expel plaintiffs' competition by withholding access to the more complex facilities.

In *McKenzie v. Mercy Hosp.*, 854 F.2d 365, 369 (10th Cir. 1988), the court quoted with approval the following elements of the doctrine:

> (1) control of the essential facility by a monopolist; (2) a competitor's inability practically or reasonably to duplicate the facility; (3) the denial of the use of the essential facility to a competitor; and (4) the feasibility of providing the facility.

The *McKenzie* court found that the plaintiff did not establish that Mercy Hospital controlled facilities essential to his medical practice. Therefore, it did not explore the other factors. In a footnote, the court said that it was leaving open the question whether, for public policy reasons, the essential facilities doctrine should *ever* apply to hospital staff privileges decisions. *Id.* at 371 n.12.

As noted, one essential element for application of the doctrine is control of the facility *by a monopolist*. The Court has already explained why it has concluded that plaintiff failed to prove that MRH has monopoly power. A relevant market must be proven, even when plaintiff is relying on the essential facilities theory. *Consul. Ltd. v. Transco Energy Co.*, 805 F.2d 490 (4th Cir. 1986). *cert. denied*, 107 S.Ct. 2182 (1987). A court may recognize submarkets under certain circumstances. *See, e.g., Case-Swayne Co. v. Sunkist Growers, Inc.*, 369 F.2d 449 (9th Cir. 1966), *cert. denied*, 387 U.S. 932, *rev'd on other grounds*, 389 U.S. 384 (1967). Plaintiffs have cited the *Case-Swayne* decision, among others, to argue that the Court may recognize a market narrower than that set out in the Complaint, and that in actuality Pittsburg County is the relevant market. *See* Plaintiffs' Motion in Limine of

November 16, 1988. In essence, this is an argument that *the Hospital* is the relevant market. One court recently stated:

> A single hospital may constitute the relevant market from the point of view of patients, yet not constitute the market for the purpose of analyzing the claims of providers of services. Several cases suggest that it would rarely be appropriate to define a single hospital as the relevant market for providers of services.
>
> *Rockland Phys. Assoc. v. Grodin*, 616 F. Supp. 945, 955 (S.D.N.Y. 1985) (citations omitted).

Under the evidence presented in this case, this Court has concluded that plaintiffs have failed to establish such a market definition. Accordingly, this claim must fail.

Conspiracy to Boycott

Plaintiffs argue that the peer review proceedings and the agreements and understandings reached in connection with them constituted a conspiracy to boycott under 15 U.S.C. §1, a *per se* unlawful restraint of trade for which all defendants are liable.

Read literally, §1 prohibits *every* agreement "in restraint of trade". Courts have interpreted the statute as prohibiting only those agreements that are "unreasonably restrictive" of competition. *See Tekton, Inc. v. Builders Bid Serv. of Utah, Inc.*, 676 F.2d 1352, 1354 (10th Cir. 1982). When addressing the merits of a Section 1 claim, a court either declares the challenged practice a *per se* violation (i.e., presumptively illegal) or applies a "rule of reason" analysis to determine whether the challenged practice

imposes an unreasonable restraint on trade. *See McKenzie, supra,* 854 F.2d at 367 n.6.

A group boycott has been held to be a *per se* violation of §1. *See, e.g., United States v. General Motors Corp.,* 384 U.S. 127, 145-46 (1966). In *Weiss v. York Hosp.,* 745 F.2d 786 (3rd Cir. 1984), *cert. denied,* 470 U.S. 1060 (1985), the court applied the *per se* analysis to a claim by osteopathic physicians. However, the court recognized that in a hospital staff privilege case in which the hospital defends based upon lack of professional ability, the rule of reason test would apply. *Id.* at 820. The court stated that "[w]e recognize . . . that in many cases involving exclusion from staff privileges, courts will, more or less openly, have to utilize a rule of reason balancing approach." *Id. See also Pontius v. Children's Hosp.,* 552 F.Supp. 1352, 1369-70 (W.D.Penn. 1982) *and Friedman v. Delaware Co. Mem. Hosp.,* 672 F.Supp. 171, 190 (E.D. Penn. 1987), *aff'd mem.,* 849 F.2d 600 (3rd Cir. 1988). The Court has determined not to invoke *per se* analysis in this case.

Plaintiffs argue that, even absent a *per se* violation, the agreements reached were unlawful under the rule of reason. They contend that the peer review proceedings were a sham to achieve anticompetitive goals. There are two essential elements to a section 1 violation: an unreasonable restraint of trade and a contract, combination or conspiracy to attain it. *Randy's Studebaker Sales, Inc. v. Nissan Motor Corp.,* 533 F.2d 510, 516 (10th Cir. 1976). *See also Skyview Distributing, Inc. v. Miller Brewing,* 620 F.2d 750, 752 (10th Cir. 1980). The issue before the Court is the application of these principles in the peer review context.

As the above citations indicate, consideration of a section 1 claim requires that one court has called a "bifurcated analysis".

> The threshold analysis requires a determination of whether some form of joint action exists to satisfy the contracts, combinations, or conspiracy requirement. It is only after concerted action is found that a court need proceed to the second part of the analysis – whether the concerted activity is an unreasonable restraint of trade.
>
> *Kreuzer v. Amer. Academy of Periodontology*, 735 F.2d 1479, 1485 (D.C. Cir. 1984).

Many antitrust plaintiffs run aground on the first, or "joint action" requirement. The United States Supreme Court has made the following pronouncement:

> The correct standard is that there must be evidence that tends to exclude the possibility of independent action . . . . That is, there must be direct or circumstantial evidence that reasonably tends to prove . . . a conscious commitment to a common scheme designed to achieve an unlawful objective.
>
> *Monsanto v. Soray-Rite Service Corp.*, 465 U.S. 752, 768 (1984).

Interpreting *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574 (1986), the Tenth Circuit has stated the following two-part evidentiary test:

> (1) is the plaintiff's evidence of conspiracy ambiguous, i.e., is it as consistent with the defendants' permissible independent interests as with an illegal conspiracy; and, if so, (2) is there any evidence that tends to exclude the

> possibility that the defendants were pursuing these independent interests.
>
> *Key Financial Planning Corp. v. ITT Life Ins. Corp.*, 828 F.2d 635, 639 (10th Cir. 1987).

In other words, the plaintiff bears the difficult burden of showing that various actors combined in a joint action. In this case, the Court has found no evidence, apart from the peer review process, that a conspiracy existed. Dr. Tarabishi's testimony regarding a tape recording of a conversation between Dr. Thurman Schuller, Dr. Bellamy and Dr. Schaff is not credible. While there was testimony that plaintiff recorded conversations surreptitiously in the Hospital, he had testified in an earlier trial that he physically overheard this particular conversation. The timing of and the many flaws in the peer review proceedings against Dr. Tarabishi do not rise to the level that the Court can infer an improper conspiracy.

In the realm of peer review, however, in one sense there is no disputing the presence of joint action. It is in the nature of peer review that various actors combine to take action of some sort. *See Miller v. Indiana Hosp.*, 843 F.2d 139, 144 n.5 (3rd Cir.), *cert. denied*, 109 S.Ct. 178 (1988) ("[T]he joint action taken by the medical staff satisfies the conspiracy requirement"). *See also Nanavati v. Burdette Tomlin Mem. Hosp.*, 857 F.2d 96, 117-118 (3rd Cir. 1988) ("[W]hen the Executive Committee acts as a body, it constitutes a 'combination' "). *and id.* at 118 (any action taken by the medical staff satisfies the "contract, combination or conspiracy" requirement of section 1). There is a split of authority as to whether a hospital is capable of forming a combination with its own staff. *Compare*

Nanavati, supra, 857 F.2d at 118 (Hospital could not conspire with the Executive Committee, based on analogy to the rule that a corporation cannot conspire with its officers and directors) *and Oltz v. St. Peter's Community Hosp.,* 861 F.2d 1440, 1450 (9th Cir. 1988) (rejecting this view, on the basis that the hospital and the medical staff are legally separate entities). The *Oltz* court relied on the decision in *Bolt v. Halifax Hosp. Med. Center,* 851 F.2d 1273 (11th Cir. 1988), which decision was subsequently vacated in preparation for *en banc* argument. 861 F.2d 1233 (11th Cir. 1988). However, the *Oltz* precedent still stands.

Defendants argue strongly against adoption of any form of this "structural conspiracy" theory, i.e., antitrust liability for mere participation in peer review coupled with anticompetitive effect. They argue that such adoption "would probably destroy the peer review process itself". (Defendants' Post-Trial Brief at 22). They properly note that per review is the norm, that it was not "invented" for Dr. Tarabishi, and that it has a legitimate and legal function. The Court must reconcile such arguments with various precedents. In *Kobe, Inc. v. Dempsey Pump Co.,* 198 F.2d 416, 425 (10th Cir.), *cert. denied,* 344 U.S. 837 (1952), the court quoted the following language:

> It is not the form of the combination or the particular means used but the result to be achieved that the statute condemns. It is not of importance whether the means used to accomplish the unlawful objective are in themselves lawful or unlawful. Acts done to give effect to the conspiracy may be in themselves wholly innocent acts. Yet, if they are part of the sum of the acts which are relied upon to effectuate the

> conspiracy which the statute forbids, they come within its prohibition.
>
> (quoting *Amer. Tobacco Co. v. United States*, 328 U.S. 781 (1946)).

See also, e.g., Consolidated Metal Prod. v. Ameri. Petro Institute, 846 F.2d 284, 294 (5th Cir. 1988) (undersection one an unreasonable restraint of trade may be established by proof of *either* an unlawful purpose or an anticompetitive effect).

Assuming *arguendo* that the mere activity of peer review constitutes joint action for section 1 purposes, the question remains whether a plaintiff need only show anticompetitive effect. Clearly, as defendants argue, such a result would virtually stifle peer review by imposing "automatic liability". Plaintiffs themselves have rejected this approach, arguing that liability should attach only when *misuse* of the peer review process may be inferred. The Court must address the question of the appropriate standard of review. In *Miller v. Indiana Hosp.*, 843 F.2d 139 (3rd Cir.), *cert. denied*, 109 S.Ct. 178 (1988), the court rejected the deferential "substantial evidence" test used by some courts, holding that it had "no place in an antitrust case where Congress has given the jury the responsibility of resolving disputed fact issues." *Id.* at 143. Obviously, in a bench trial, the Court has the same responsibility. The *Miller* court does not indicate what standard is to be substituted. The defendants assert that

> the court's inquiry be confined to determination of: (1) whether the plaintiff was involved in one or more incidents raising legitimate questions about welfare of patients or the hospital; (2) whether the physicians involved in the peer

> review were free of direct financial motivation to cause harm to the plaintiff; and (3) whether the results of the peer review process appear to bear some relationship to the nature and gravity of the offense or offenses charged.
>
> (Defendants' Post-Trial Brief at 26).

Reference has also been made to the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§11101 *et seq*. The Court has ruled in its Order of June 10, 1988, that this Act, applicable to peer review actions commenced on or after November 14, 1986, does not apply in the case at bar. Nevertheless, it sets forth certain criteria which, logically, a reviewing court might ultimately consider. 42 U.S.C. §11111(a) sets forth the scope of immunity. §11112(a) provides:

> For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken –
>
> (1) In the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter.
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).
>
> A professional review action shall be presumed to have met the preceding standards necessary

> for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

It is clear that even under the heightened standard represented by section 11112, a district court is entitled to thoroughly examine the peer review proceedings.

The detailed examination in this case of the peer review proceedings involving Dr. Tarabishi leads the Court to the conclusion that the proceedings would *not* pass muster, even under the deferential standard described above. In many instances, there was *not* "a reasonable effort to obtain the facts of the matter" or to provide adequate notice. The record is replete with examples. The witnesses were not personally interviewed regarding the Darby case. The Committee merely read reports. In the Amber Weaver matter, the Committee did not talk to the patient's mother, but reached a conclusion that Dr. Tarabishi had not seen her preoperatively. In the Ketcherside matter, although Mrs. Ketcherside contradicted Dr. McCauley's account, she was not directly talked with by the Committee. In d.ex.68-155 at page 219, the Committee states that Dr. Tarabishi was invited to appear but "declined to answer questions". It is clear from page 216 that Dr. Tarabishi had only been provided with Dr. Boyer's letters ten minutes before the hearing began. Other instances could be cited. The deficiencies in these peer review proceedings go far beyond a failure to observe "procedural niceties", as defendants seek to characterize them. Tainting the entire process was the personal animus of many of the defendants toward Dr. Tarabishi. In one breath, a defendant doctor in this trial would testify that he virtually despised Dr. Tarabishi; in

the next, he would testify that he could be and was "fair and impartial" while sitting in judgment. These assertions of objectivity are, quite simply, not credible. It was made clear to the Court that many of the defendant doctors would have taken Dr. Boyer's word over Dr. Tarabishi's in any circumstance. The Court cannot, by any rational definition of the term, "approve" the peer review proceedings under review. The issue, however, is whether they constitute an antitrust violation.

The question of intent has occupied much of the post-trial briefing in this case. The requisite intent in a §1 civil case is only a general intent, that is, that each party acted with the intention that his acts have the consequences they did have, and with the knowledge that at least one other actor would act in conjunction with him. 2 Von Kalinowski, *Antitrust Laws & Trade Regulation* §6.01[3] (1989). *See also Bank of Utah v. Commercial Security Bank,* 369 F.2d 19, 26 (10th Cir. 1966), *cert. denied,* 386 U.S. 1018 (1967) (intent to restrain trade is not essential to Section 1 violation). *Contra, SI Handling Systems, Inc. v. Heisley,* 658 F.Supp. 362, 378 (E.D. Penn. 1986) (intent necessary for a §1 violation must be an anti-competitive intent). Certainly, those participating in peer review are aware that revocation of a doctor's privileges will affect his ability to compete. Thus, it appears that plaintiffs are correct that, in theory, a §1 violation may be shown from the mere fact of peer review accompanied by the requisite impact *upon competition.*

The Court stresses the last two words of the preceding sentence because a rule of reason analysis requires not merely an examination of impact upon the claimant,

but rather upon the balance of anticompetitive and procompetitive effects within the relevant market. *See, e.g., Hornsby Oil Co., Inc. v. Champion Spark Plug Co.*, 714 F.2d 1384, 1392-93 (5th Cir. 1983). The basic principles of market definition used in Section 2 cases may be used in Section 1 cases. *Id.* at 1393 n.9.

For the reasons previously stated, the Court finds plaintiffs' market definitions to be flawed. Further, the only impact upon *competition*, as distinguished from plaintiffs, is based upon the speculation that THD would ultimately become a hospital. The Court finds this speculation to be tenuous. No showing was made of an effect on competition within the relevant market and the Court concludes that judgment must be entered for defendants on this basis.

Conspiracy to Stabilize Prices

Plaintiffs have also asserted a Section 1 violation through a conspiracy to stabilize prices. The United States Supreme Court has declared such a conspiracy illegal *per se*. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940). However, this Court again declines to extend the *per se* category beyond its present boundaries. The Court must again examine the conspiracy issue.

Under a rule of reason analysis, the Court finds no evidence of such a price stabilization conspiracy, whether directly or through the effect of the peer review proceedings. The Court must reject this claim. The Court's finding of no conspiracy also disposes of plaintiffs' state law claim under 21 O.S. §421.

Immunity

The Court hereby reaffirms its prior rulings that defendants are not immune under the "state action" doctrine or under the Local Government Antitrust Act of 1984, 15 U.S.C. §§34-36. On the second asserted immunity, the defendants' most recent citation of *Sandcrest Outpatient Services v. Cumberland County Hosp. Sys., Inc.*, 853 F.2d 1139 (4th Cir. 1988) is not particularly helpful, because the critical issue – whether the Hospital System is a local government unit – was not raised on appeal. *Id.* at 1142.

To the extent that these Conclusions of Law constitute Findings of Fact, they shall be so considered.

CONCLUSION

This litigation was the Court's first exposure to the hospital peer review process. The Court was shocked to discover that a physician's career can be – and in this instance has been – destroyed through patently improper proceedings. Peer review, as it is presently practiced, is fundamentally flawed. The purpose of monitoring physicians' conduct is laudable and necessary; however, to accomplish that purpose, the review must be conducted by disinterested parties who have examined all of the pertinent evidence. The only issue in this trial was whether defendants committed antitrust violations. (By the time plaintiffs' present counsel entered the case, the statute of limitations had run on other causes of action.) The Court has concluded that no antitrust violation occurred in this instance, although precedent in this area remains in flux. But the Court is convinced that unless

fundamental reform is made in peer review, litigation will continue to proliferate.

It is the Order of the Court that judgment be entered in favor of defendants and against plaintiffs.

IT IS SO ORDERED this 4th day of May, 1989.

/s/ H. Dale Cook
H. DALE COOK
United States District Judge

AMENDMENT 14

Section 1. [Citizenship – Due process of law – Equal protection.]

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

§ 1. Trusts, etc., in restraint of trade illegal; penalty

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

§ 2. Monopolizing trade a felony; penalty

Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

CHAPTER 117. ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

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§ 11101. Findings

The Congress finds the following:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law,

unreasonably discourages physicians from participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

(Nov. 14, 1986, P. L. 99-660, title IV, § 402, 100 Stat. 3784.)

PROMOTION OF PROFESSIONAL REVIEW ACTIVITIES

§ 11111. Professional review

(a) In general. (1) Limitation on damages for professional review actions. If a professional review action (as defined in section 431(9) [42 USCS § 11151(9)]) of a professional review body meets all the standards specified in section 412(a) [42 USCS § 11112(a)], except as provided in subsection (b) –

(A) the professional review body,

(B) any person acting as a member or staff to the body,

(C) any person under a contract or other formal agreement with the body, and

(D) any person who participates with or assists the body with respect to the action,

shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq. and the Civil Rights Acts, 42

U.S.C. 1981, et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 4C of the Clayton Act, 15 U.S.C. 15C, [15 USCS § 15c] where such an action is otherwise authorized.

(2) Protection for those providing information to professional review bodies. Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.

(b) Exception. If the Secretary has reason to believe that a health care entity has failed to report information in accordance with section 423(a) [42 USCS § 11133(a)], the Secretary shall conduct an investigation. If, after providing notice of noncompliance, an opportunity to correct the noncompliance, and an opportunity for a hearing, the Secretary determines that a health care entity has failed substantially to report information in accordance with section 423(a) [42 USCS § 11133(a)], the Secretary shall publish the name of the entity in the Federal Register. The protections of subsection (a)(1) shall not apply to an entity the name of which is published in the Federal Register under the previous sentence with respect to professional review actions of the entity commenced during the 3-year period beginning 30 days after the date of publication of the name.

(c) Treatment under State laws. (1) Professional review actions taken on or after October 14, 1989. Except as provided in paragraph (2), subsection (a) shall apply to State laws in a State only for professional review actions commenced on or after October 14, 1989.

(2) Exceptions. (A) State early opt-in. Subsection (a) shall apply to State laws in a State for actions commenced before October 14, 1989, if the State by legislation elects such treatment.

(B) State opt-out. Subsection (a) shall not apply to State laws in a State for actions commenced on or after October 14, 1989, if the State by legislation elects such treatment.

(C) Effective date of election. An election under State law is not effective, for purposes of subparagraphs (A) and (B), for actions commenced before the effective date of the State law, which may not be earlier than the date of the enactment of that law.

(Nov. 14, 1986, P. L. 99-660, Title IV, Part A, § 411, 100 Stat. 3784.)

§ 11112. Standards for professional review actions

(a) In general. For purposes of the protection set forth in section 411(a) [42 USCS § 11111(a)], a professional review action must be taken –

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved

or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3). A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 411(a) [42 USCS § 11111(a)] unless the presumption is rebutted by a preponderance of the evidence.

(b) Adequate notice and hearing. A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action. The physician has been given notice stating –

(A) (i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B) (i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing. If a hearing is requested on a timely basis under paragraph (1)(B), the

physician involved must be given notice stating –

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice. If a hearing is requested on a timely basis under paragraph (1)(b) –

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) –

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right –

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right –

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3).

(c) Adequate procedures in investigations or health emergencies. For purposes of section 411(a) [42 USCS § 11111(a)], nothing in this section shall be construed as –

(1) requiring the procedures referred to in subsection (a)(3) –

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

(Nov. 14, 1986, P. L. 99-660, Title IV, Part A, § 412, 100 Stat. 3785.)

§ 11113. Payment of reasonable attorneys' fees and costs in defense of suit.

In any suit brought against a defendant, to the extent that a defendant has met the standards set forth under section 412(a) [42 USCS § 11112(a)] and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

(Nov. 14, 1986, P. L. 99-660, Title IV, Part A, § 413, 100 Stat. 3787.)

§ 11114. Guidelines of the Secretary

The Secretary may establish, after notice and opportunity for comment, such voluntary guidelines as may assist the professional review bodies in meeting the standards described in section 412(a) [42 USCS § 11112(a)], (Nov. 14, 1986, P. L. 99-660, Title IV, Part A, § 414, 100 Stat. 3787.)

§ 11115. Construction

(a) In general. Except as specifically provided in this part [42 USCS §§ 11111 et seq.], nothing in this part [42 USCS §§ 11111 et seq.] shall be construed as changing the liabilities or immunities under law.

(b) Scope of clinical privileges. Nothing in this part [42 USCS §§ 11111 et seq.] shall be construed as requiring health care entities to provide clinical privileges to any or all classes or types of physicians or other licensed health care practitioners.

(c) Treatment of nurses and other practitioners. Nothing in this part [42 USCS §§ 11111 et seq.] shall be construed as affecting, or modifying any provision of Federal or State law, with respect to activities of professional review bodies regarding nurses, other licensed health care practitioners, or other health professionals who are not physicians.

(d) Treatment of patient malpractice claims. Nothing in this title [42 USCS § 11101 et seq.] shall be construed as affecting in any manner the rights and remedies afforded patients under any provision of Federal or State law to seek redress for any harm or injury suffered as a result of negligent treatment or care by any physician, health care practitioner, or health care entity, or as limiting any

defenses or immunities available to any physician, health care practitioner, or health care entity.

(Nov. 14, 1986, P. L. 99-660, Title IV, Part A, § 415, 100 Stat. 3787.)

REPORTING OF INFORMATION

§ 11131. Requiring reports on medical malpractice payments

(a) In general. Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with section 424 [42 USCS § 11134], information respecting the payment and circumstances thereof.

(b) Information to be reported. The information to be reported under subsection (a) includes –

(1) the name of any physician or licensed health care practitioner for whose benefit the payment is made,

(2) the amount of the payment,

(3) the name (if known) of any hospital with which the physician or practitioner is affiliated or associated,

(4) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based, and

(5) such other information as the Secretary determines is required for appropriate interpretation of information reported under this section.

(c) Sanctions for failure to report. Any entity that fails to report information on a payment required to be reported under this section shall be subject to a civil money penalty of not more than $10,000 for each such payment involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act [42 USCS § 1320a-7a] are imposed and collected under that section.

(d) Report on treatment of small payments. The Secretary shall study and report to Congress, not later than two years after the date of the enactment of this Act [enacted Nov. 14, 1986], on whether information respecting small payments should continue to be required to be reported under subsection (a) and whether information respecting all claims made concerning a medical malpractice action should be required to be reported under such subsection.

(Nov. 14, 1986, P. L. 99-660, Title IV, Part B, § 421, 100 Stat. 3788.)

§ 11132. Reporting of sanctions taken by Boards of Medical Examiners

(a) In general. (1) Actions subject to reporting. Each Board of Medical Examiners –

(A) which revokes or suspends (or otherwise restricts) a physician's license or censures, reprimands, or places on probation a

physician, for reasons relating to the physician's professional competence or professional conduct, or

(B) to which a physician's license is surrendered, shall report, in accordance with section 424 [42 USCS § 11134], the information described in paragraph (2).

(2) Information to be reported. The information to be reported under paragraph (1) is –

(A) the name of the physician involved,

(B) a description of the acts or omissions or other reasons (if known) for the revocation, suspension, or surrender of license, and

(C) such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.

(b) Failure to report. If, after notice of noncompliance and providing opportunity to correct noncompliance, the Secretary determines that a Board of Medical Examiners has failed to report information in accordance with subsection (a), the Secretary shall designate another qualified entity for the reporting of information under section 423 [42 USCS § 11133].

(Nov. 14, 1986, P. L. 99-660, Title IV, Part B, § 423, 100 Stat. 3789.)

§ 11133. Reporting of certain professional review actions taken by health care entities

(a) Reporting by health care entities. (1) On physicians. Each health care entity which –

(A) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days;

(B) accepts the surrender of clinical privileges of a physician –

(i) while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or

(ii) in return for not conducting such an investigation or proceeding; or

(C) in the case of such an entity which is a professional society, takes a professional review action which adversely affects the membership of a physician in the society,

shall report to the Board of Medical Examiners, in accordance with section 424(a) [42 USCS § 1134(a)], the information described in paragraph (3).

(2) Permissive reporting on other licensed health care practitioners. A health care entity may report to the Board of Medical Examiners, in accordance with section 424(a) [42 USCS § 11134(a)], the information described in paragraph (3) in the case of a licensed health care practitioner who is not a physician, if the entity would be required to report such information under paragraph (1) with respect to the practitioner if the practitioner were a physician.

(3) Information to be reported. The information to be reported under this subsection is –

(A) the name of the physician or practitioner involved,

(B) a description of the acts or omissions or other reasons for the action or, if known, for the surrender, and

(C) such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.

(b) Reporting by Board of Medical Examiners. Each Board of Medical Examiners shall report, in accordance with section 424 [42 USCS § 11134], the information reported to it under subsection (a) and known instances of a health care entity's failure to report information under subsection (a)(1).

(c) Sanctions. (1) Health care entities. A health care entity that fails substantially to meet the requirement of subsection (a)(1) shall lose the protections of section 411(a)(1) [42 USCS § 11111(a)(1)] if the Secretary publishes the name of the entity under section 411(b) [42 USCS § 11111(b)].

(2) Board of Medical Examiners. If, after notice of noncompliance and providing an opportunity to correct noncompliance, the Secretary determines that a Board of Medical Examiners has failed to report information in accordance with subsection (b), the Secretary shall designate another qualified entity for the reporting of information under subsection (b).

(d) References to Board of Medical Examiners. Any reference in this part [42 USCS §§ 11131 et seq.] to a Board of Medical Examiners includes, in the case of a Board in a State that fails to meet the reporting requirements of section 422(a) [42 USCS § 11132(a)] or subsection

(b), a reference to such other qualified entity as the Secretary designates.

(Nov. 14, 1986, P. L. 99-660, Title IV, Part B, § 423, 100 Stat. 3789.)

§ 11134. Form of reporting

(a) Timing and form. The information required to be reported under sections 421, 422(a), and 423 [42 USCS §§ 11131, 11132(a), 11133] shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date (not later than one year after the date of the enactment of this Act [enacted Nov. 14, 1986]) specified by the Secretary.

(b) To whom reported. The information required to be reported under sections 421, 422(a), and 423(b) [42 USCS §§ 11131, 11132(a), 11133(b)] shall be reported to the Secretary, or, in the Secretary's discretion, to an appropriate private or public agency which has made suitable arrangements with the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of the information under this part [42 USCS §§ 11131 et seq.].

(c) Reporting to State licensing boards. (1) Malpractice payments. Information required to be reported under section 421 [42 USCS § 11131] shall also be reported to the appropriate State licensing board (or boards) in the State in which the medical malpractice claim arose.

(2) Reporting to other licensing boards. Information required to be reported under section 423(b) [42 USCS

§ 11133(b)] shall also be reported to the appropriate State licensing board in the State in which the health care entity is located if it is not otherwise reported to such board under subsection (b).

(Nov. 14, 1986, P. L. 99-660, Title IV, Part B, § 424, 100 Stat. 3790.)

§ 11135. Duty of hospitals to obtain information

(a) In general. It is the duty of each hospital to request from the Secretary (or the agency designated under section 424(b) [42 USCS § 11134(b)]) on and after the date information is first required to be reported under section 424(a) [42 USCS § 11134(a)][)] –

(1) at the time a physician or licensed health care practitioner applies to be on the medical staff (courtesy or otherwise) of, or for clinical privileges at, the hospital, information reported under this part [42 USCS §§ 11131 et seq.] concerning the physician or practitioner, and

(2) once every 2 years information reported under this part [42 USCS §§ 11131 et seq.] concerning any physician or such practitioner who is on the medical staff (courtesy or otherwise) of, or has been granted clinical privileges at, the hospital.

A hospital may request such information at other times.

(b) Failure to obtain information. With respect to a medical malpractice action, a hospital which does not request information respecting a physician or practitioner as required under subsection (a) is presumed to have

knowledge of any information reported under this part to the Secretary with respect to the physician or practitioner.

(c) Reliance on information provided. Each hospital may rely upon information provided to the hospital under this title [42 USCS §§ 11101 et seq.] and shall not be held liable for such reliance in the absence of the hospital's knowledge that the information provided was false.

(Nov. 14, 1986, P. L. 99-660, Title IV, Part B, § 425, 100 Stat. 3790.)

§ 11136. Disclosure and correction of information

With respect to the information reported to the Secretary (or the agency designated under section 424(b) [42 USCS § 11134(b)]) under this part [42 USCS §§ 11131 et seq.] respecting a physician or other licensed health care practitioner, the Secretary shall, by regulation, provide for –

(1) disclosure of the information, upon request, to the physician or practitioner, and

(2) procedures in the case of disputed accuracy of the information.

(Nov. 14, 1986, P. L. 99-660, Title IV, Part B, § 426, 100 Stat. 3791.)

§ 11137. Miscellaneous provisions

(a) Providing licensing boards and other health care entities with access to information. The Secretary (or the agency designated under section 424(b) [42 USCS § 11134(b)]) shall, upon request, provide information reported under this part with respect to a physician or

other licensed health care practitioner to State licensing boards, to hospitals, and to other health care entities (including health maintenance organizations) that have entered (or may be entering) into an employment or affiliation relationship with the physician or practitioner or to which the physician or practitioner has applied for clinical privileges or appointment to the medical staff.

(b) Confidentiality of information. (1) In general. Information reported under this part [42 USCS §§ 11131 et seq.] is considered confidential and shall not be disclosed (other than to the physician or practitioner involved) except with respect to professional review activity, as necessary to carry out subsections (b) and (c) of section 425 [42 USCS § 11135(b), (c)] (as specified in regulations by the Secretary), or in accordance with regulations of the Secretary promulgated pursuant to subsection (a). Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure. Information reported under this part [42 USCS §§ 11131 et seq.] that is in a form that does not permit the identification of any particular health care entity, physician, other health care practitioner, or patient shall not be considered confidential. The Secretary (or the agency designated under section 424(b) [42 USCS § 11134(b)]), on application by any person, shall prepare such information in such form and shall disclose such information in such form.

(2) Penalty for violations. Any person who violates paragraph (1) shall be subject to a civil money penalty of not more than $10,000 for each such violation involved. Such penalty shall not be imposed and collected in the

same manner as civil money penalty of not more than $10,000 for each such violation involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act [42 USCS § 1320a-7a] are imposed and collected under that section.

(3) Use of information. Subject to paragraph (1), information provided under section 425 [42 USCS § 11135] and subsection (a) is intended to be used solely with respect to activities in the furtherance of the quality of health care.

(4) Fees. The Secretary may establish or approve reasonable fees for the disclosure of information under this section or section 426 [42 USCS § 11136]. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary (or, in the Secretary's discretion, to the agency designated under section 424(b) [42 USCS § 11134(b)]) to cover such costs.

(c) Relief from liability for reporting. No person or entity (including the agency designated under section 424(b) [42 USCS § 11134(b)]) shall be held liable in any civil action with respect to any report made under this part [42 USCS §§ 11131 et seq.] (including information provided under subsection (a)[)] without knowledge of the falsity of the information contained in the report.

(d) Interpretation of information. In interpreting information reported under this part [42 USCS §§ 11131 et seq.], a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.

(Nov. 14, 1986, P. L. 99-660, Title IV, Part B, § 427, 100 Stat. 3791; Dec. 1, 1987, P. L. 100-177, Title IV, § 402(a), (b), 101 Stat. 1007.)

DEFINITIONS AND REPORTS

§ 11151. Definitions

In this title [42 USCS §§ 11101 et seq.]:

(1) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.

(2) The term "Board of Medical Examiners" includes a body comparable to such a board (as determined by the State) with responsibility for the licensing of physicians and also includes a subdivision of such a Board or body.

(3) The term "clinical privileges" includes privileges, membership on the medical staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care by a health care entity.

(4)(A) The term "health care entity" means –

(i) a hospital that is licensed to provide health care services by the State in which it is located,

(ii) an entity (including a health maintenance organization or group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health

care (as determined under regulations of the Secretary), and

(iii) subject to subparagraph (B), a professional society (or committee thereof) of physicians or other licensed health care practitioners that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary).

(B) The term "health care entity" does not include a professional society, (or committee thereof) if, within the previous 5 years, the society has been found by the Federal Trade Commission or any court to have engaged in any anti-competitive practice which had the effect of restricting the practice of licensed health care practitioners.

(5) The term "hospital" means an entity described in paragraphs (1) and (7) of section 1861(e) of the Social Security Act [42 USCS § 1395x(e)(1), (7)].

(6) The terms "licensed health care practitioner" and "practioner" mean, with respect to a State, an individual (other than a physician) who is licensed or otherwise authorized by the State to provide health care services.

(7) The term "medical malpractice action or claim" means a written claim or demand for payment based on a health care provider's furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages.

(8) The term "physician" means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized).

(9) The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. In this title, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on –

(A) the physician's association, or lack of association, with a professional society or association,

(B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business.

(C) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,

(D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or

(E) any other matter that does not relate to the competence or professional conduct of a physician.

(10) The term "professional review activity" means an activity of a health care entity with respect to an individual physician –

(A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,

(B) to determine the scope or conditions of such privileges or membership, or

(C) to change or modify such privileges or membership.

(11) The term "professional review body" means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.

(12) The term "Secretary" means the Secretary of Health and Human Services.

(13) The term "State" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(14) The term "State licensing board" means, with respect to a physician or health care provider in a State, the agency of the State which is primarily responsible for the licensing of the physician or provider to furnish health care services.

(Nov. 14, 1986, P. L. 99-660, Title IV, Part C, § 431, 100 Stat. 3792.)

§ 11152. Reports and memoranda of understanding

(a) Annual reports to Congress. The Secretary shall report to Congress, annually during the three years after the date of the enactment of this Act [enacted Nov. 14, 1986], on the implementation of this title [42 USCS §§ 11101 et seq.].

(b) Memoranda of understanding. The Secretary of Health and Human Services shall seek to enter into memoranda of understanding with the Secretary of Defense and the Administrator of Veterans' Affairs to apply the provisions of part B of this title [42 USCS §§ 11131 et seq.] to hospitals and other facilities and health care providers under the jurisdiction of the Secretary or Administrator, respectively. The Secretary shall report to Congress, not later than two years after the date of the enactment of this Act [enacted Nov. 14, 1986], on any such memoranda and on the cooperation among such officials in establishing such memoranda.

(c) Memorandum of understanding with Drug Enforcement Administration. The Secretary of Health and Human Services shall seek to enter into a memorandum of understanding with the Administrator of Drug Enforcement relating to providing for the reporting by the Administrator to the Secretary of information respecting physicians and other practitioners whose registration to dispense controlled substances has been suspended or revoked under section 304 of the Controlled Substances Act [21 USCS § 824]. The Secretary shall report to Congress, not later than two years after the date of the enactment of this Act [enacted Nov. 14, 1984], on any such memorandum and on the cooperation between the Secretary and the Administrator in establishing such a memorandum.

(Nov. 14, 1986, P. L. 99-660, Title IV, Part C, § 432, 100 Stat. 3794.)

§ 11111. Professional review

(a), (b) [Unchanged]

(c) **Treatment under State laws.** (1) [Unchanged]

(2) Exceptions. (A) [Unchanged]

(B) Effective date of election. An election under State law is not effective, for purposes of [subparagraph (A)], for actions commenced before the effective date of the State law, which may not be earlier than the date of the enactment of that law.

(C) [Redesignated]

(As amended Dec. 19, 1989, P. L. 101-239, Title VI, Subject A, Part 2, Subpart A, § 6103(e)(6)(A), 103 Stat. 2208.)

§ 11115. Construction

(a) In general. Except as specifically provided in this part, nothing in this part shall be construed as changing the liabilities or immunities under law or as preempting or overriding any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by this part.

(b)-(d) [Unchanged]

(As amended Dec. 19, 1989, P. L. 101-239, Title VI, Subtitle A, Part 2, Subpart A, § 6103(e)(6)(A), 103 Stat. 2208.)